STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH EQUITY

MEETING OF THE
OFFICE OF HEALTH EQUITY (OHE)
ADVISORY COMMITTEE

THE CALIFORNIA ENDOWMENT

1414 K STREET, SUITE 500

SACRAMENTO, CALIFORNIA

TUESDAY, SEPTEMBER 30, 2014

9:00 A.M.

Reported by: John Cota

A P P E A R A N C E S

Committee Members

Rocco Cheng, PhD, Co-Chair

Sandi Gálvez, MSW, Co-Chair (Oakland)

Sergio Aguilar-Gaxiola, MD, PhD

Jeremy Cantor, MPH (Oakland)

Yvonna Cázares

Aaron Fox, MPM (Los Angeles)

Álvaro Garza, MD, MPH

Cynthia Gomez, PhD (San Francisco)

Pastor Willie Graham

Carrie Johnson, PhD (Los Angeles)

Neal Kohatsu, MD, MPH

Dexter Louie, MD, JD, MPA

Francis Lu, MD (San Francisco)

Gail Newel, MD, MPH (Fresno)

Teresa Ogan, MSW

Hermia Parks, MA, RN, PHN (Los Angeles)

Diana Ramos, MD, MPH (Los Angeles)

Patricia Ryan, MPA

Linda Wheaton, MURP, AICP

Ellen Wu, MPH (Oakland)

A P P E A R A N C E S

State Officials/Staff Speakers

Ron Chapman, MD, MPH, CDPH Director & Public Health Officer

Jahmal Miller, MHA, OHE Deputy Director

Katie Belmonte, Staff Counsel

Karen Ben-Moshe, Health in All Policies Coordinator (San Francisco)

Julia Caplan, Health in All Policies Director (Oakland)

Andrea Garcia, MD, California Department of Public Health, Preventive Medicine Resident (Los Angeles)

Carol Gomez, AGPA, Special Assistant to the Deputy Director

Kimberly Knifong, Associate Governmental Program Analyst

Meredith Lee, Health Program Specialist I (Oakland)

Kelsey Lyles, Health in All Policies Associate I

Thi Mai, Research Scientist I

Tamu Nolfo, PhD, OHE Special Consultant

Mallika Rajapaksa, Research Scientist IV

Aimee Sisson, MD, MPH, OHE Public Health Medical Officer

A P P E A R A N C E S

Also Present

Dalila Butler (Oakland)
PolicyLink

Domenica Giovannini
Marin City Community Services District

Jerry Jeffe
California Chronic Care Coalition

Gary Mendoza (Los Angeles)
Health eWay, Inc.

Ricardo Moncrief (via teleconference)

Lilyane Glamben
ONTRACK Program Resources

Robert Lipton (via teleconference)

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P R O C E E D I N G S

9:05 a.m.

DR. NOLFO: Good morning, everyone. Thank you for joining us. If you experience any technology problems, which I'm hoping that you're not, of course you can speak with the operator. We are actually going to start the meeting with our Director of the California Department of Public Health; Dr. Ron Chapman is going to do a welcome and some updates for you.

CDPH DIRECTOR CHAPMAN: So welcome all. Thank you for attending the Office of Health Equity Advisory Committee meeting. As always, I am truly appreciative of your participation. We are trying a new strategy during this meeting which is quite interesting; we have folks all over the state in public locations. I know you have a packed agenda so I'll just take a few minutes to, again, welcome all of you and give a short introduction.

I, unfortunately, will not be able to sit through the meeting; I've got to run back to the office. It's getting near the end of the 30 days that the Governor has to sign bills that are on his desk, we still have a few pending from Public Health.

So again, welcome.

I think I am going to kick it off first with an apology. As you all know, we are all sitting on the edge of

our seats waiting for the release of our Strategic Plan and Report. And I must say that we were not expecting it to take this long. I should share with you that we also were not expecting to have as much scrutiny and review of this document and that's a good thing and a bad thing.

The good part is that a lot of very, very important people are reviewing these documents. The challenge is that most of them have never heard of health equity. This is a great opportunity for Jahmal and myself and the team to educate these important people on health equity. Unfortunately, that takes a lot of time.

So I really appreciate all of your patience with this process. It is moving along. I wish I could tell you -- I wish I knew when it will be released; I'm hoping soon. For me, I just do not want to let us see the bureaucracy stand in the way of progress.

We have got a lot of other great work going on while we're waiting for this report. The office itself is getting fully staffed up. We have got a lot of recruitments and hiring going on, very excited about that.

We have a new, revised Strategic Map for the California Department of Public Health. This is our second version. I am very happy to say that this version has a cross-cutting strategic priority which says the Department will achieve health equity through public health programs.

And we have a new strategic objective on the map which says, "Drive the policy agenda. And I am very excited to share that we have an executive level team that is going to be working on this particular strategic objective. I am the lead with Monica Wagner, their Deputy Director of Leg and Governmental Affairs. And with the support of the entire executive team we have chosen health equity to be the first issue that we are going to work on in this objective of driving the policy agenda.

So we are going to be looking within the Department how we can achieve health equity through public health programs, through our administrative processes, through a number of different areas. These are all areas under our control within the Department and I am really happy that the executive team has placed health equity as the top priority for driving the policy agenda within the Department.

So that's my introduction and, again, I welcome everyone and I look forward to hearing about the great work and outcome of the meeting today. Thank you.

DR. NOLFO: Thank you. Thank you so much.

Operator, if you could please switch over to Sandi Gálvez.

AC CO-CHAIR GÁLVEZ: Hello.

DR. NOLFO: Hi, Sandi.

AC CO-CHAIR GÁLVEZ: Can you all hear me?

DR. NOLFO: Yes. Sandi, can you hear us? Yes, we can hear you.

AC CO-CHAIR GÁLVEZ: Okay. Good morning, everyone. I would like to welcome you to our advisory committee meeting. I hope that you all had a great summer and are ready to start working on this important work again.

To begin with I want to go around and find out who is present and so in order to facilitate that we'll do one site at a time. And I'd like -- and I'd ask that you do a round robin around the table of who is present from the advisory committee at each site.

So we'll start here at the Oakland site.

AC MEMBER WU: Ellen Wu with Urban Habitat.

AC MEMBER CANTOR: Jeremy Cantor with JSI in San Francisco.

AC CO-CHAIR GÁLVEZ: And then from the public?

MS. BUTLER: Dalila Butler with PolicyLink.

AC CO-CHAIR GÁLVEZ: And staff present?

MS. CAPLAN: Julia Caplan with Health in All Policies, OHE. And Meredith Lee just stepped out of the room but she is here as well in Oakland from OHE.

AC CO-CHAIR GÁLVEZ: Okay, why don't we do our Sacramento group next.

AC MEMBER OGAN: Teresa Ogan with MSSP in

Sacramento.

AC MEMBER GRAHAM: Willie Graham.

AC MEMBER KOHATSU: Neal Kohatsu, Department of Health Care Services.

AC MEMBER LOUIE: Dexter Louie, National Council of Asian/Pacific Islander Physicians.

AC CO-CHAIR GÁLVEZ: I'm sorry, could you please repeat that last one, I couldn't hear you.

AC MEMBER LOUIE: Dexter Louie, National Council of Asian/Pacific Islander Physicians.

AC MEMBER RYAN: Patricia Ryan, the County Behavioral Health Directors Association.

DR. NOLFO: And we also have a number of staff in the room here.

OHE DEPUTY DIRECTOR MILLER: Jahmal Miller, Office of Health Equity.

DR. NOLFO: Tamu Nolfo, Office of Health Equity.

MS. MAI: Thi Mai.

MS. RAJAPAKSA: Mallika Rajapaksa, from Office of Health --

AC CO-CHAIR GÁLVEZ: You guys are getting faint.

CDPH DIRECTOR CHAPMAN: They can't hear you unless you go to the microphone.

MS. RAJAPAKSA: Thi and Mallika.

MS. MAI: Thi and Mallika, Office of Health

Equity.

MS. LYLES: Kelsey Lyles, Office of Health Equity.

DR. SISSON: Aimee Sisson, Office of Health Equity.

MS. GOMEZ: Carol Gomez.

MS. KNIFONG: Kimberly Knifong.

MS. BELMONTE: Katie Belmonte, Office of Legal Services.

MR. JEFFE: From the public, Jerry Jeffe, California Chronic Care Coalition.

MS. GIOVANNINI: And Domenica Giovannini from the Marin City Community Services District.

AC CO-CHAIR GÁLVEZ: Could the last person please speak up.

MS. GIOVANNINI: Domenica Giovannini from the Marin City Community Services District.

DR. NOLFO: And that's everyone here.

AC CO-CHAIR GÁLVEZ: Great. How about at our San Francisco group?

DR. NOLFO: So for the operator, that means that you need to unmute the line for Carrie Johnson, please.

Oh, I'm sorry, for San Francisco. I think it's Karen Ben-moshe that's in San Francisco.

AC MEMBER GOMEZ: Hi, can you hear us?

DR. NOLFO: Yes.

AC MEMBER GOMEZ: Hi, this is Cynthia Gomez, San Francisco State Health Equity Institute.

AC MEMBER LU: Francis Lu, UC Davis.

MS. BEN-MOSHE: And this is Karen Ben-moshe, I'm staff with the Office of Health Equity.

AC CO-CHAIR GÁLVEZ: Is there anybody from the public present?

(No response.)

AC CO-CHAIR GÁLVEZ: Okay, so can we move to our Los Angeles group?

DR. NOLFO: And that would be Carrie Johnson.

AC MEMBER JOHNSON: Carrie Johnson, United American Indian Involvement.

MR. MENDOZA: Gary Mendoza, Health eWay.

DR. NOLFO: Gary Mendoza is a member of the public?

MR. MENDOZA: Yes.

DR. GARCIA: Andrea Garcia, Resident Physician.

DR. NOLFO: Carrie, is there anyone else in Los Angeles?

AC MEMBER JOHNSON: No.

DR. NOLFO: Okay, thank you.

Our last site is Fresno. Operator, that would be Gail Newel.

AC MEMBER NEWEL: Hello, this is Gail, can you

hear me?

DR. NOLFO: Yes.

AC MEMBER NEWEL: I'm alone here so far.

DR. NOLFO: Thank you for holding down the fort.

AC MEMBER NEWEL: You betcha.

(Laughter.)

AC CO-CHAIR GÁLVEZ: Tamu, is anybody taking notes?

DR. NOLFO: Yes, we actually have a transcriptionist.

AC CO-CHAIR GÁLVEZ: Because I want to -- it was a little hard to hear everybody so I'm not sure we have a quorum. Can that be confirmed?

DR. NOLFO: Yes, if you give me just a moment. We are missing a number of people actually, I am not sure that we do have a quorum. So I have 3, 6, 9, 10. So I'm counting 10, which is not a quorum. I'm sorry, there's 11, Neal is here; 12, Patricia. Hang on one second and let me see.

OHE DEPUTY DIRECTOR MILLER: We're validating the count.

AC CO-CHAIR GÁLVEZ: Okay.

DR. NOLFO: So we actually are shy by one member and we may get another member because we do have Yvonna Cázares who sent me an e-mail saying that she would be

running late this morning. So maybe we want to hold off on any items that require voting until we can get one more member.

AC CO-CHAIR GÁLVEZ: Okay, well that's most of the items on the first part of the agenda other than presenting the agenda itself.

DR. NOLFO: I'm sorry, would you say that one more time, Sandi.

AC CO-CHAIR GÁLVEZ: That would be then moving basically all of the items on the 9:10-10:00 a.m. part of the agenda other than presenting the agenda itself.

DR. NOLFO: Right.

AC CO-CHAIR GÁLVEZ: Would be moved to later.

DR. NOLFO: I think that we can do that.

(Dr. Nolfo conferred with Ms. Belmonte.)

DR. NOLFO: So we're going to start with doing updates and see if we get another member of the advisory committee to join us at one of the sites.

OHE DEPUTY DIRECTOR MILLER: Did you hear that, Sandi?

AC CO-CHAIR GÁLVEZ: Yes.

OHE DEPUTY DIRECTOR MILLER: Okay. So we're going to jump to --

AC MEMBER RAMOS: Hello?

DR. NOLFO: Yes.

AC CO-CHAIR GÁLVEZ: Hello.

AC MEMBER RAMOS: Hi, this is Dr. Diana Ramos in Los Angeles calling in. I couldn't announce myself. I know you needed one more person for a quorum.

AC CO-CHAIR GÁLVEZ: Wait, but are you present at the meeting or you're calling in separately?

AC MEMBER RAMOS: From my office.

AC CO-CHAIR GÁLVEZ: That doesn't count.

AC MEMBER RAMOS: Okay. So if I go to the site then it counts?

AC CO-CHAIR GÁLVEZ: Yes, then it counts. You have to be at one of the publicly noticed locations.

AC MEMBER RAMOS: Well, I can be there in 15 minutes.

AC CO-CHAIR GÁLVEZ: Okay.

DR. NOLFO: Thank you, Diana, appreciate that. All right, fantastic.

OHE DEPUTY DIRECTOR MILLER: So we are going to amend the agenda to do all the updates and then come back to that?

DR. NOLFO: Yes.

OHE DEPUTY DIRECTOR MILLER: Okay. So is it on me?

DR. NOLFO: It is on you.

OHE DEPUTY DIRECTOR MILLER: Are you cool, Sandi,

with jumping to the OHE Updates and coming back?

AC CO-CHAIR GÁLVEZ: Yes.

OHE DEPUTY DIRECTOR MILLER: Okay.

AC CO-CHAIR GÁLVEZ: I don't think we -- well, do you think we need to actually go over what is on the agenda?

OHE DEPUTY DIRECTOR MILLER: Yes, that's fine.

AC CO-CHAIR GÁLVEZ: All right. So the first part of the morning here was going to be to do our business section of the meeting, including approving our minutes, considering our bylaws and hopefully approving them and then talking about staggered membership terms. But we'll hold off until Diana arrives at the other office to be able to jump into those items.

The next part, Jahmal, Tamu and Aimee will be providing updates on the OHE.

Then Julia and Linda will be presenting an update on the Health in All Policies Task Force.

Neal will be presenting an update on the Department of Health Care Services.

And then the final part of the meeting, we're going to be discussing the future direction of our advisory committee, what are we going to be doing next. And here an update from Tamu on some interviews she has done with the advisory committee members to solicit some input of what folks would like to see happen with the advisory committee

now that our work on the Strategic Plan is complete.

Throughout the process I would like to remind the public that we do have opportunities to provide feedback on all of these items. We do encourage you to fill out speaker cards, which I am not actually sure we have present, and announce yourself prior to making your comment.

And I guess that's it. So we'll turn to Jahmal and Tamu and Aimee. If you are all ready we'll move into that -- into the OHE Update section of the agenda.

DR. NOLFO: Thank you, Sandi. And I will also mention we actually don't have speaker cards. But if you are a member of the public and you would like to speak if you can just indicate that to us.

OHE DEPUTY DIRECTOR MILLER: Great. Well good morning, everyone, it's been awhile. But as you all know, approximately a year ago is when we launched the first steering committee meeting. And I hadn't started yet, I was a few days away from starting.

What a difference a year makes. We have had a numerous amount of opportunities to engage with each with each other and I am thankful today that we were able to get kind of creative and innovative to accommodate all of our statewide committee members and other stakeholders and staff to leverage the advent of technology. And I appreciate --

AC CO-CHAIR GÁLVEZ: Jahmal, I'm sorry to

interrupt you. Is there going to be a PowerPoint presentation associated with your update?

OHE DEPUTY DIRECTOR MILLER: No.

AC CO-CHAIR GÁLVEZ: Okay.

DR. NOLFO: There is going to be one when Dr. Sisson comes on in a few minutes and that's the California Reducing Disparities Project Update. So if at the various sites, if you could bring that up that would be fantastic.

OHE DEPUTY DIRECTOR MILLER: So just a verbal update.

AC CO-CHAIR GÁLVEZ: Thank you.

OHE DEPUTY DIRECTOR MILLER: Okay. So yes, I'm grateful to Tamu and the team and the other folks who contributed to facilitating today's meeting and I want to just use this opportunity to provide some quick updates. There has been so much activity since our last meeting which was, I believe, in May. And this has been an extremely busy summer and we have had opportunities to connect with all of our committee members either in person, by phone or in a variety of other ways.

And particularly around the Senate Confirmation which was quite a big deal, not for me but really for our office. I had the opportunity to go before both the Senate Rules Committee on July 2nd to be unanimously voted to have

my position confirmed; and then in August to have the California State Senate unanimously uphold that Senate Rules Committee decision. And that was big. Once again, not for me but for our office. Because, once again, it validates how the legislation was written to really elevate the status of our office in the California Department of Public Health but also our opportunity to have an elevated presence in the Agency. And particularly with the Legislature, where the policy makers are. And they are going to be critical parts and pieces of our ability to move our health equity agenda forward.

Many of you as committee members were either present, you testified on our behalf, you authored letters of support. Some of you might have even prayed or offered up good thoughts on our behalf. And it all worked affirmatively so thank you so much, that was an important milestone for our office. Fortunately, we had no opposition, just constructive opportunities to really educate people around what health equity is, what our charge is and some important projects that we have underway and ultimately what it is that we plan to accomplish. So thank you to everyone for your support in the Senate confirmation process.

You got an e-mail a few weeks ago from us. I wanted to ensure that we shared with our committee members

and the general public new job postings that we have in the Office of Health Equity so that we can get the word out about new job opportunities that will be forthcoming. I believe we posted in the last post -- how many positions was it?

DR. NOLFO: A total of six.

OHE DEPUTY DIRECTOR MILLER: We posted six positions to date within the last couple of weeks. We have been getting a lot of positive hits. We have other duty statements that are currently under review that we will be posting as well. So any support you can lend to referring people to get on the state lists as far as job classifications and examinations go, we encourage that. We want to search far and wide to make sure that we get the best talent in the Office of Health Equity. Particularly those who understand this work, to provide not only demographic diversity but really, you know, intellectual thought partners who get this work and allow us to go deeply into our efforts of transforming government and operationalizing health equity and working well with our partners in the communities across the state of California.

And we have a great deal of support from our leadership, the Directorate's Office, in being creative in how we find financial resources to staff and also redirecting positions from other programs within the

California Department of Public Health so that we can prepare ourselves to implement not only our statewide plan but to carry out the mandate for our office, which is pretty complex and is going to require a lot of support. And that makes our jobs easier to do.

We have been involved, just quickly, with some special work forces and task forces, one being the California Central Steering Committee. I don't know if many of you are familiar with ACES or the Adverse Childhood Experiences, it's a body of work that addresses trauma and the implications of trauma on children and ultimately as they become adults. We have partnered with one of our colleagues in the California Department of Public Health in that work in ensuring that we have a strong strategic plan around addressing trauma and adverse childhood experiences with our kids.

The California proposal that we submitted to the US Department of Justice, which was -- I think it's still being led by Attorney General Eric Holder, was recently accepted. Attorney General Kamala Harris led the charge to pull together a multi-dimensional team that is focused on this Defending Childhood policy initiative. And I am a core member, a public health core member on this team of 10 people, and our proposal -- our policy proposal was recently accepted. And we will be going to Washington DC soon to

create the state's strategic plan on how we deal with the effects of violence in the communities, particularly that's adversely impacting and affecting our children.

We also are planting the seeds in establishing what we call the private foundation brain trust. If you'll recall, in the mandate for our office we are required to work with federal, state and private entities. And private foundations and philanthropies have, at the national level and at the state level, a significant amount of funding allocated towards health equity initiatives. And we definitely want to tap into special funds and general funds from a state perspective but we also want to leverage the opportunities that are presented by many private foundations.

So this brain trust, which I would envision our advisory committee obviously being connected to, is literally going to be a group of national executives from these major foundations. And ultimately sharing our Health Equity Statewide Plan with them so that they can identify, based on their funding priorities, how they want to invest into the Office of Health Equity. We are really excited about that. As you know we need resources to do this work.

And as I just wrap up. Yesterday I had the opportunity to -- over the last few months I have been on a planning committee with the Federal Reserve Bank of San

Francisco. And yesterday here in Sacramento over 300 people attended our Health Communities Summit, which brought together a cross-sector of private and public entities that are investing strategically in sustainable communities around transportation, land use, health in all policies and a variety of other focused efforts on how we stimulate local economies to factor in equity at the end of the day to ensure that all people re benefiting from gentrifying both our inner cities and our suburbs and ensuring that all people have an opportunity at the table.

And we, once again, we talked about transportation, housing, social services. Many of our staff at the Office of Health Equity made some sort of contribution to yesterday's meeting; but the Office of Health Equity was front and center. And we have not just a voice at the table but play an instrumental role at being a convener in bringing everyone from banks to local investment, you know, entities, to the table to figure out how do we leverage equity and include equity into our discussions around economic development, transportation planning and such.

And I'll -- just two final notes. I've had the honor of serving on a planning committee on behalf of the Office of Health Equity on a charge that is led by the California Endowment. It's called the Health Equity Awards.

The Health Equity Awards is about recognizing local health departments across the state who are doing health equity work well. We put out a call several months ago for applications for these health equity awards. And when they are awarded later on this year the grand prize, if you will, is going to be $100,000. And then based on small, medium and large jurisdictions, going to award, respectively, $25,000 in each category.

And the vision with Dr. Tony Iton and Sandra Witt at the California Endowment is to encourage health equity within local public health departments and to recognize those health departments that are doing the work and to invest in them so that they can continue to do the work.

But ultimately we want to make sure that we are messaging and sharing across the state these best practices. So it is not so much about the winners but it is really taking the 13 applicants and elevating, sharing information about how they are hard-wiring health equity into their work. And I will ensure that all of you get more information about that electronically.

And then lastly, the Speakers Office. Toni Atkins reached out to us a few months ago with the prospect of the Office of Health Equity co-chairing an interagency task force for boys and men of color. There is a national effort underway in the My Brother's Keeper Initiative addressing

the disproportionate around health equity and inequities of health -- inequities and disparities that we're seeing among brown and Latino boys and others, in Native American, geographically isolated and in Asian communities. And we are fleshing out what that is going to look like. But we are kind of being drafted -- and using these examples of how the Office of Health Equity is being drafted into many of these statewide efforts.

So that's my update.

And just a quick comment on what Dr. Chapman said around our waiting on the approval of the Health Equity Statewide Plan. We as an office have been -- have learned of late, and our Health in All Policies team members have experienced it, I know Dr. Sisson and Marina Augusto have experienced it around the CRDP, definitely Tamu, myself, Dr. Chapman and Kathleen Billingsley have experienced it with the Health Equity strategic plan, is that we have a rich, rich opportunity internal to government to really bring our colleagues along and to hard-wire not just an understanding of what health equity is but the application of it. Whether it's how we contract, how we can have the ability to expedite these reviews of these very important plans that we are looking forward to implementing.

So one of my priorities is that we really get serious about internal training and development, applying

even at the duty statement level, an expectation that people who work not just in CDPH and in DHCS but Agency at large, that there is an expectation that we have this understanding of what health equity is all about. And we're going to need all of our members of the Committee as well as public experts in our ability to do that well around training and development and we have some good ideas on how we can do that. So with that said, I yield the mic to the next person in line.

DR. NOLFO: Thank you. I am Tamu Nolfo, Special Consultant with the Office of Health Equity. I just wanted to say a few words about the Strategic Plan and the strategic planning process.

I really wanted to thank everyone who participated in it. If you have been along on this journey for the past year you know that it has been a rather intense journey and it culminated in the spring with a lot of activity during several advisory committee meetings where folks broke out into small groups with advisory committee members coupled with staff and members of the public to really flesh through the good thinking that went into creating the Strategic Plan.

We also had a 61 item survey that many people responded to. I read every single one of the surveys that came in. I had letters that came into the office; we had

many e-mails that came into the office where people were able to express what they wanted to see in the Strategic Plan and all of that was taken into consideration.

The last charge that was given to me at the May advisory committee meeting was to in some ways simplify how we were going to present the Strategic Plan and the goals for the Strategic Plan. And so in the version that is being reviewed at this time that has been taken into consideration.

And essentially there are three main thrusts in the Strategic Plan and the first is around assessment. It's really getting a lay of the land around where are the opportunities to do better work around health equity and also what are the possibilities, what are the best practices that are out there that we could be integrating, that we could be capitalizing on, that we could be bringing to scope.

And the second main thrust in the strategic plan is communication. So it's communicating what it is that we find. Making sure that all of us are getting on the same page around not only what the problems are, what the needs are, but also what the possibilities are so we don't kind of fall into this position of despair that these issues are so large that we don't even know where we start, we don't even really know what can be done.

And then the third area is around infrastructure development or capacity development. So that we can develop as we need to, to be able to address this really monumental task.

And the three audiences, if you will, where all of this is going to be directed, take place going towards the health partners or potential health partners that we see. In one of the earlier versions they were called non-health partners and the feedback that came through on, I believe the last advisory committee meeting was, that's the wrong terminology. We don't want to think about them as non-health partners and we don't want them to think of themselves as non-health partners, we want to think of them as potential health-partners. And so that's reaching out to transportation and housing and business and education and all of the folks that we need to be a part of this movement; so that is one strategic audience.

The other strategic audience is the health field itself. We know that we can be doing better within the health field and we are going to strive to do that.

And the third area is communities. That's a huge thrust. We want to empower communities to really be able to take on this work, to be well-resourced to take on this work. To spread their findings, be able to bring their findings up to scale. To be able to disseminate what they

are doing well.

And so those are the three main focal areas or audiences, if you will, where we are going to be directing the assessment, the communication and the infrastructure development.

So that strategic plan is coupled with the demographic report that also was taking shape alongside it and that really is an analysis of the social determinants of health that we were directed within statute to address and to be able to highlight, to take stock of within, you know, this report form at least once every two years. And what we decided was to put both that demographic report and the strategic plan together into one document and that is what is being currently reviewed. So that's kind of a snapshot about what you should be expecting to see once it goes through the administrative review process.

And also just to kind of piggyback on Jahmal's comments in terms of really being visible and being transparent about the work that we are doing and reaching out to new partners. That we have been very busy over the last several months in doing that and making presentations to NHSA partners, to Teresa Ogan's group, the Site Directors Association working with seniors. That there have been -- even here at Cal Endowment there have been a number of partners that we have been reaching out to. One of the

public members that we have in Los Angeles, Gary Mendoza, many different conversations in terms of how can we really look at bringing life to the strategic plan? Who do we need to have involved in the implementation of the strategic plan?

And so those are my comments about the strategic plan and I am going to turn it over to Dr. Aimee Sisson to give you an update on the California Reducing Disparities Project.

AC CO-CHAIR GÁLVEZ: Excuse me, before we transition over can all sites please put their phones on mute, we are getting a lot of background noise; I'm hearing background conversations.

DR. NOLFO: Operator, if you can help us with that, that would be great.

I am also going to mention while I have the line. I see that Aaron Fox has called in, he is an advisory committee member. And Aaron, if you are able to join the LA site then we can count you towards the quorum.

We also were joined by Dr. Álvaro Garza who is one of our advisory committee members as well and so we actually do have a -- and Yvonna Cázares also stepped in so we actually do have a quorum at this time.

AC MEMBER JOHNSON: Hello? This is Carrie Johnson from Los Angeles. We actually have two more advisory

committee members here.

AC MEMBER PARKS: Hermia Parks, Riverside County, Director of Public Health Nursing.

AC MEMBER RAMOS: And Dr. Diana Ramos. I had called in earlier.

DR. NOLFO: Thank you so much.

DR. SISSON: Okay. So this is Aimee Sisson from the Office of Health Equity and I am going to present to you an update on the California Reducing Disparities Project today. Please forgive me in advance for speaking quickly because I am trying to cover about 30 minutes of material.

AC CO-CHAIR GÁLVEZ: You need to get closer to the phone.

DR. SISSON: Is this one not on?

DR. NOLFO: Maybe pull that one over to you.

DR. SISSON: Is that better? Sorry, this is Aimee Sisson, Public Health Medical Officer with the Office of Health Equity and I am presenting an update on the California Reducing Disparities Project today. Can you hear me now or have you been muted so we won't know? We'll assume everything is good.

(Laughter.)

DR. SISSON: So as I was saying, please forgive me in advance for speaking quickly because I am covering about 30 minutes of material in hopefully 20 minutes or so. But I

am presenting off a slide set, as Tamu mentioned earlier, and that is available on the OHE website for those of you who are calling in remotely. Hopefully it's also available at each of the five remote locations.

DR. NOLFO: And so if you would just tell us when you are going to the next slide then everyone can know.

DR. SISSON: And the order may have changed slightly since they were posted but I trust that you will able to follow along.

So today I am planning to update you on our draft CRDP Strategic Plan that Ruben Cantu from the California Pan-Ethnic Health Network, or CPEHN, presented to the Office of Health Equity Advisory Committee in May; share our design for the next phase of CRDP, or what we are calling CRDP Phase 2, including how we are going to roll out the $60 million worth of Mental Health Services Act funds; and finally touch on the immediate next steps for the program.

So next slide. Just to quickly review the overall project design for those of you who haven't thought about CRDP since May.

Phase 1 was focused on developing a strategic plan to reduce mental health disparities among five California target populations, African Americans, Asian-Pacific Islanders, Native Americans, Latinos and Lesbian, Gay, Bisexual, Transgender, Queer and Questioning persons.

Phase 2 focuses on implementing that strategic plan with an emphasis on funding community-defined evidence programs related to mental health to provide and rigorously evaluate their services to determine whether such services are effective.

Just so we are on the same page, when I refer to "community-defined evidence" I mean a set of practices that communities have used and determine to yield positive results as determined by community consensus over time, that may or may not have been measured empirically but have reached a level of acceptance by the community.

So, next slide. As you will recall from Ruben's May presentation, the CRDP strategic plan has already been written but it has not yet been approved by our Health and Human Services Agency for public release.

We are keeping our fingers crossed that approval will come in the near future, at which time we will enter into a 30 day public comment period, during which CDPH and the CRDP strategic planning work group leads will host several community forums seeking public input on the draft plan.

After the public comment period the plan will be revised based on public feedback. That will take about six weeks.

And then we will enter the finalization process,

during which the plan will be professionally designed and made pretty for its final publication and release.

Next slide. Even though the CRDP strategic plan has not been finalized the draft plan has provided many recommendations for our CDPH team to work with in planning the next phase of CRDP. In fact, the draft strategic plan has been the main informing document for our Phase 2 work to date.

In addition to receiving guidance from the recommendations in the strategic plan we have also been guided by interviews with numerous key informants, both from within the Department of Public Health and from the targeted communities. And these include experts in program design, evaluation and mental health, including Rachel Guerrero, the former Director of the Office of Multiculturral Services at the Department of Mental Health where the CRDP originated.

We have also established what we are calling the CRDP Brain Trust. And if I can say, CRDP had that term before Jahmal stole it.

(Laughter.)

DR. SISSON: But that is an informal advisory committee comprised of independent subject matter experts who are familiar with the target populations and who have expertise related to mental health, community-defined evidence, reducing mental health disparities and/or

evaluation.

Moving forward, the fourth bullet point on the slide, public vetting expresses our intent to solicit public input on the program design and make adjustments accordingly.

I want to acknowledge up front that the framework that I am sharing today is a work in progress, it is still under development. There's a lot of details that still need to be worked out. But we are sharing what we have so far now so we can start getting feedback on the general design as we move forward.

Next slide. So the big picture of CRDP Phase 2 begins with the vision.

As stated on the slide, we envision a California in which all individuals, regardless of race, ethnicity, sexual orientation or gender identity, will receive quality mental health prevention and treatment services delivered in a culturally and linguistically competent manner.

This is a big goal and we recognize that it won't be achieved overnight or even at the end of Phase 2.

But we do expect to make progress toward the vision in the short term and will measure that progress in at least four ways, including whether the community-defined evidence programs that are funded in Phase 2 are effective in preventing or decreasing the severity of mental illness

or promoting mental health.

Second, whether the validated programs are being funded by other entities outside of CRDP Phase 2, such as county mental health agencies.

And finally, whether the targeted communities have new seats at the table or even new tables at which to advocate for community mental health needs.

Next slide. To make the vision of CRDP a reality the project will be guided by four core principles.

The first of these principles is doing business differently. This involves listening to the community by seeking input and then being responsive to that input.

The second principle is building community capacity. In order for the Phase 2 efforts to be at least somewhat sustainable beyond the funded period we need to invest in technical assistance and training that builds organizational capacity by teaching community-based organizations how to fish so that they can eat for a lifetime, not just giving them a fish so that they can eat for a day, or in this case, five years.

The third principle is fairness. As the slide states: a program that is designed to reduce disparities must be certain not to perpetuate them. One piece of fairness is leveling the playing field so that programs that aren't typically funded are able and supported to apply.

This principle is at the root of the capacity building projects that I'll discuss in a minute.

And finally, the last underlying principle is systems change. Like the capacity building principle this one also relates to sustainability and it explains why Phase 2 is not just about community-defined evidence pilot projects but also about infrastructure building so as to change the context in which the pilot projects are operating.

Next slide. So with this slide we are starting to zoom in a little bit more on what we will actually be funding with our $60 million in Phase 2 funds.

Phase 2 is comprised of the five components shown here.

The majority of funding, 60 percent, is directed at community-defined evidence pilot projects, which are at the heart of Phase 2.

Approximately 25 percent of program funds are dedicated to evaluation. We recognize that this is higher than the typical 10 to 15 percent for evaluation seen with most public health programs, but we feel that the above average proportion is necessary to conduct a rigorous, community participatory and mixed methods evaluation of all of CRDP Phase 2 as well as of the individual pilot programs.

Ten percent of the funding is for technical

assistance and training. And that's to support the pilot sites in planning, implementing and evaluating their programs.

Approximately 5 percent of the funds are dedicated or directed for infrastructure building, which essentially is systems change work.

And finally, the administration of CRDP by CDPH does cost money. We are making efforts to minimize our administrative costs and we are also planning to fund the administrative costs from outside of the $60 million Phase 2 allocation, which is why you don't see a percentage attached to the last bullet.

Next slide. So how do the five program components from the previous slide fit together. This slide, which some people have called the "seating chart" because it reminds them of a wedding banquet --

(Laughter.)

DR. SISSON: -- attempts to depict the big picture, or as I think of it, the forest of CRDP. And in the following slide we are going to start to explore the trees of the forest but I find it helpful to have the big picture context first.

This is definitely a complicated slide. I encourage you to come back to it later. But for now please note that there's five pods, one for each of the CRDP target

populations shown on the periphery. And in the center we have the California Department of Public Health providing an oversight and administrative role along with the statewide evaluation team that includes a lead evaluator for each of the five populations.

And finally, at the top you can see the infrastructure component, which is comprised of one statewide and five local outreach education and awareness coordinators.

Next slide. Zooming in on one of the five population pods, in this case the Latino example. You can see that each pod is comprised of five to seven pilot projects with six shown in the diagram, which will be spread across California. Each pilot project is supported by a population-specific technical assistance provider along with a population-specific evaluator from the statewide evaluation team.

Each pilot project is also associated with a mental or behavioral health department from its respective county, but the nature of this last association will be up to each pilot project. Although we are encouraging pilots to link with their respective county mental health department and will be providing solicitation scoring incentives such as bonus points to the applicants for meaningful collaboration with their county mental health

department.

Next slide. So moving on to the next component, the pilot projects. These pilot projects are community-defined evidence programs that will implement, expand and evaluate their existing promising practice in order to demonstrate that the practice is, indeed, effective. Projects must address mental health prevention and early intervention.

We anticipate funding two different types of pilot projects, capacity building pilots and implementation pilots.

The capacity building pilots will receive approximately $25,000 over six months, along with extensive administrative and evaluation, technical assistance and training, so that they are prepared to enter the next phase of implementation.

Three capacity building pilot sites will be funded for each of the five populations for a total of 15 capacity building sites. Our hope is that each selected capacity building site will successfully complete the program and enter the implementation cohort.

The successful capacity building sites will be joined by approximately 20 other pilot sites with higher initial capacity in the implementation stage for a total of 25 implementation pilots.

During the implementation phase the pilots will receive approximately $200,000 a year for four years to expand their programs and they will receive an additional $60,000 to evaluate their programs.

The pilots themselves will be nonprofit, community-based organizations primarily, but county mental health departments will also be eligible to apply.

A critical criterion for selecting the pilot sites will be their experience working directly with the target population in a culturally sensitive manner.

Next slide. So just to recap the pilots on this time line. During the first six months of Phase 2 there would be 15 capacity building pilots. These capacity building pilots would be joined by 20 others for the next four years of the program, bringing the total to 35 implementation pilot sites.

Next slide. And actually go to the next slide, Tamu. So this is the evaluation slide. Sorry, I shifted order a little bit after publication.

So we are proposing that the evaluation of CRDP Phase 2 occur at three levels, pilot site, population wide and statewide.

At the pilot level, each site will perform its own community-based participatory evaluation using a mix of qualitative and quantitative methods. Some pilot sites may

have existing evaluation staff but we anticipate that most of the pilots will need to hire an evaluator using their evaluation funding.

Each pilot site will determine its outcomes of interest based on the specific intervention and target population, but some core outcomes will be collected for all of the pilot sites within a population.

Which brings us to the population level evaluation.

DR. NOLFO: Aimee, could I get you to hold for just one moment. Never mind, they are back in; Oakland had gotten disconnected.

DR. SISSON: Okay. The population level evaluation aims to support a level of consistency and design methodology and outcome measures across all the pilots for a given population.

And similarly, the statewide evaluation will provide an additional level of consistency across all of the pilot projects and populations, in addition to evaluating the overall Phase 2 program.

The overall statewide evaluation will consider research questions such as: How effective was the TA that was provided to the pilot sites? Did the infrastructure component result in systems change? And if so, what?

And just finally, at all of the levels the focus

of evaluation is really on the determination of whether the project or the program is effective in doing what it is intending to do.

So going back to the technical assistance slide. As I noted earlier, the pilot projects will be supported by technical assistance and training. This technical assistance will take one of two forms. Sorry these are a little hard to see on the screen. Administration-focused or evaluation-focused technical assistance and it will differ for the capacity building sites and the implementation sites.

Administrative technical assistance will be provided by a population-specific TA provider. That is, each population will have its own technical assistance-providing organization, which will be culturally sensitive.

Administrative TA to the capacity building sites will be focused on supporting smaller organizations to apply for funding through proposal development support.

While administrative TA to the implementation pilots will include support in contracting and program management, budgeting, human resources and sustainability planning.

The administrative TA provider will also help the implementation pilots to broker relationships between the pilots and CDPH and also between the pilots and their

respective county mental health department.

Much like the administrative TA, the evaluation technical assistance will be provided by a population-specific provider who is a member of the statewide evaluation team and possesses cultural competence and sensitivity.

The evaluation technical assistance to the capacity building pilots will involve articulating the project's theory of change or logic model, as well as evaluation planning.

And finally, the implementation pilots will receive evaluation TA on evaluation planning, design and actual implementation such as data collection, along with support to seek validation as an evidence-based practice if they decide to do so.

Next slide. The infrastructure component has been developed to address policy and system change so that at the end of Phase 2 we don't have a lot of community-defined evidence projects that have been validated going up against a system that is still unready to accept or fund them.

There's two main pieces of infrastructure to be developed during Phase 2. The first is to establish an advisory committee that will advise CDPH specifically on the CRDP as well as on the bigger picture of mental health disparities.

And the second piece is the establishment of education outreach and awareness coordinators at the statewide and local levels to increase community involvement in mental health policy, programs and planning.

Next slide. So the final tree or component in our CRDP forest is administration.

Based on the proposed program design, we are anticipating that CDPH will need to develop and oversee approximately 60 contracts and grants during Phase 2.

Our current program staff for CRDP will need to be expanded, as we will need staff to oversee these contracts as well as to support and oversee the evaluation, design and implementation.

Finally, as I noted earlier, we do intend to fund administration separately from the $60 million allocation for Phase 2 in order to maximize the funds that are going to communities in need.

Next slide. Just as we will ask all of the pilot site applicants to do, we have developed a logic model to articulate how CRDP Phase 2 intends to achieve its goal of reducing mental health disparities, which is shown at the far right.

As you work your way from left to right on the slide you can see how the program inputs, including $60 million of Mental Health Services Act funding, technical

assistance, administrative support, community guidance in the form of the CRDP strategic plan, along with solicitation incentives, will come together through activities such as pilot project infrastructure pieces along with an ongoing, across-the-board evaluation shown at the top, to lead initially to validated, community-defined evidence programs, increase community capacity, and later to increased funding for community-defined evidence programs, increase culturally appropriate services and policy and systems change, ultimately leading to reduced mental health disparities.

Next slide. Turning our proposed program design from theory into reality and getting the Phase 2 funds out the door will involve multiple solicitations, through which potential providers and pilot sites can apply for funding.

These solicitations, or funding opportunity announcements, will be rolled out in stages, starting with a statewide evaluation team and their population-specific technical assistance providers, both of which will be needed to support the capacity building pilot projects, which will be really second. The third round of solicitations will procure approximately 20 additional pilot sites to join the capacity-building pilot sites as implementation pilots.

And then the final round of solicitations will bring on a single statewide education outreach and awareness coordinator along with five local coordinators.

Next slide. Our proposed program design is just that, a proposal, and we are seeking public input on this Phase 2 approach. We want to get this right and the more eyes on the design, the better. We be will seeking public input through three primary mechanisms.

First, in the information gathering phase, which is happening now. We are or will be talking to subject matter experts, conducting community forums and surveying potential pilot sites to learn more about their programs and needs.

Second, we'll share draft solicitations with the public prior to their formal release requesting feedback on the drafts.

And finally, even after the solicitations are released, bidders can provide feedback on the requirements if they feel any are unreasonable.

Next slide. In the next few weeks we will be releasing a survey aimed at potential pilot site applicants to learn more about their existing capacity as well as their current needs in order to help us design the pilot site and the technical assistance provider solicitations.

This fall we are hoping to hold several community forums to get input on the proposed program and solicitation design.

And also coming soon for public review and comment

will be the first draft solicitation, which will be the statewide evaluation team.

And feedback on the draft solicitations will help us get this right so that we can use the CRDP Phase 2 funding to have the largest possible impact on reducing mental health disparities in California.

Next slide. That's really all I have to say. If you have specific questions that we don't get to today I encourage you to send questions or comments to our CRDP electronic mailbox, which is crdp@cdph.ca.gov. And also to visit our CRDP website on the CDPH Office of Health Equity page. We will be updating that frequently throughout our Phase 2 roll-out. Thank you.

AC CO-CHAIR GÁLVEZ: Thank you. Sandi, I am not quite sure how you want to handle discussion. If you want us to see if there are members of the advisory committee -- by the way, we were joined by another member of the advisory committee, Linda Wheaton, here in Sacramento. If you want to do it site by site as a check-in?

AC CO-CHAIR GÁLVEZ: Yes. I mean, does each site have the capacity to let you know electronically if someone wants to speak?

DR. NOLFO: Operator, can you help me with that?

THE OPERATOR: Yes. We can either do a formal Q&A session where the participants press *1 on their phone and

I'll open their line or you can just have everyone's line opened at once, it's up to you.

AC CO-CHAIR GÁLVEZ: Well first we're going to have comment by the advisory committee members only, if there is comment to be had, then we will have public comment, so I don't want to have all the lines open just yet, just the lines for the different sites.

And actually going forth I would like to keep the lines open for all the sites and ask site to keep it on mute, in the event that a site wants to make a comment about something or ask a question I don't want to not have you have the opportunity to do that because you're forced mute.

I guess going forward let's just start in Sacramento. Are there any comments or questions from any of the advisory committee members?

DR. NOLFO: It looks Pat Ryan has a question or a comment.

AC MEMBER RYAN: I really -- it's more of a comment than anything else. Being in mental health, county mental health for many years I have been following this process. I just want to compliment you on the presentation and the organization of how this process has evolved and is rolling out. It's just really well thought out and really well-organized.

Based on what I know of this whole process it

seems like you have been listening to a very broad array of people in the mental health community. I just want to compliment you on that. It's taken longer than I expected it to take but when you're doing things well I think that that often happens. I think it's really, really well-organized.

I also am happy to see that you are allowing counties to apply, because there are a lot of really great things that are happening in counties as a result of the outreach and engagement that they have been doing over the past few years so I think it's great that they will be allowed as well as the other community providers to apply.

And finally I think it's great that you are incentivizing and encouraging non-county providers to work with counties. Because if this is going to be successful over the long-term it is going to need to have county funding and it needs to be incorporated into the long-term county programs that will be there hopefully for a long time. So I think that's great also. So, kudos.

DR. NOLFO: We have Dr. Kohatsu and then Pastor Willie Graham.

AC MEMBER KOHATSU: So thanks very much for that presentation, it was very helpful. Just since I'm from DHCS and obviously work with our Mental Health and Substance Abuse Disorders Services Program.

I saw near the end there were various state agency coordination. And I'm sorry I couldn't attend the last meeting so I apologize if it was covered before. But how does, because of their relationship with local agencies, and I totally understand getting it out to the community makes total sense. But just as I share back with our department, how do you work with the MH Subs Program within DHCS or if there is a connection there?

DR. SISSON: This is Aimee. We have met with some of the folks over at the Department of Health Care Services about the project but it was more on the information gathering phase and getting a better understanding of, at least for myself who is fairly new to the mental health world, how all the pieces fit together with the various state agencies and counties and how funding flows. Whether there is criteria or whether it's a requirement that you have an evidence-based practice in order to be reimbursed for funding with state funds. I think you raise an excellent point that we should increase the level of coordination with our sister agencies.

AC MEMBER KOHATSU: And that's great that you did reach out. I'm planning just one other comment as -- just to Patricia's, building on that comment. I totally agree that we want to look more broadly at how this becomes integrated in the fabric of care. And everyone, at least in

our area in our department is working on behavioral health/physical health integration.

So to the extent, Aimee, that the team can work with the folks in MH within DHCS that will be helpful as we think broadly about a health system that is not just physical health and not just behavioral health but also the social dimensions.

I am very excited about what you laid out s a plan and I think engaging my colleagues will be helpful to other efforts so thanks for reaching out.

DR. NOLFO: Yes, Pastor Willie Graham.

AC MEMBER GRAHAM: Okay, my question to you is, how do you go about -- first I want to understand "nonprofit organization." Are you referring to the nonprofit organization, any nonprofit organization? Some nonprofit organizations may not yet be registered with the Secretary of State as an organization, as a 501(c)(3). You might have some that are just starting out, beginning to work, are working but have not yet processed the paperwork. Will you be working with both nonprofit, those who are not yet registered with the Secretary of State as well as those who are?

DR. SISSON: That's a good question and I -- I should have caveated this Q&A period with: our program is still under development and so we haven't -- we haven't

determined all of the eligibility criteria for each of the solicitations. The pilot site solicitations are sort of the first ones out the door so we aren't as far along on those so I don't have an answer for that today.

We are looking to fund nonprofits or government entities. Whether the technicality of the registration with the Secretary of State, that's not something that has come up in our discussions. I will make a note of it and we will make a determination moving forward. But unfortunately I can't answer that today.

AC MEMBER GRAHAM: Can we call by a later time to try to find out the answer to that?

DR. SISSON: Yes. And when the draft solicitations come out we will share that with the advisory committee.

AC MEMBER GRAHAM: Okay.

DR. SISSON: And so you will be able to see at that point which side we come down on and weigh in on whether you feel that's appropriate or not.

AC MEMBER GRAHAM: Okay, thanks.

AC MEMBER CÁZARES: Thanks, Aimee, for the presentation.

DR. SISSON: Sure.

AC MEMBER CÁZARES: I thought it was great.

DR. NOLFO: Announce yourself.

AC MEMBER CÁZARES: Yvonna Cázares. So I just have a question. The implementation sites --

AC CO-CHAIR GÁLVEZ: Yvonna, can you please speak up.

AC MEMBER CÁZARES: Sure. So the implementation sites, are they different from the pilot sites? And if so, what is the relationship between the location sites and the pilot sites, if they are different?

DR. SISSON: They are both -- so there's two kinds of pilot sites, there's capacity-building pilot sites and implementation pilot sites. So generically we refer to them as pilot projects to encompass both groups but the plan is that we would start with a smaller group of the capacity-building pilot sites. They get their extensive technical assistance and training and essentially go through a boot camp. And then the final exam, so to speak, at the end of the capacity-building phase will be to submit an application for the implementation.

But they wouldn't be -- they wouldn't be competing directly with the larger capacity CBOs for the implementation spots. They essentially would move right into the implementation phase if they successfully complete the capacity-building phase. So that for the first six months we just have 15 projects and then we add 20 more. And then those are all -- all 35 of them are considered

implementation pilots. So the capacity-building pilots graduate to become implementation pilots.

AC MEMBER CÁZARES: Okay, thank you for that, making that clear.

And then I just look forward to the eligibility criteria because I know in working with school districts, so many of them have invested more in services, especially around mental health, for families and children, as a result of local control funding formula and other funds. So if this is an entity -- if school districts would be considered a government agency eligible to apply, this would be great for them to supplement that investment.

DR. NOLFO: Álvaro Garza.

AC MEMBER GARZA: Thank you. So you mentioned the pilot sites are going to be geographically spread. This question is regarding geographic spread. Is there going to be some equitable distribution to rural and urban and monolingual speakers so we don't lose, for example, the farm workers and other bi-national type groups throughout the state?

DR. SISSON: We don't have a quota, for example, for any one or specific geographic regions. Originally in our thinking we had divided the state up into the five normal mental health regions that now CBHDA uses. And then we felt that that was a little too arbitrary because the

population for the five racial, ethnic and cultural groups of CRDP isn't necessarily evenly spread throughout the state. And so we really want to target where there is population where there is need and not do it in an arbitrary manner.

Right now we will probably just include the language in the solicitations about getting a broad geographic spread and not have any arbitrary requirements about that. And then it will be kind of the final staff and review committee determination about the final spread. But, you know, we don't want to end up with five projects in one specific area of the state.

AC MEMBER GARZA: Right.

DR. SISSON: We want them to be spread out.

OHE DEPUTY DIRECTOR MILLER: I want to add to that as well. And that's where the value of sharing this update is important with you all as committee members to be kind of the ambassadors with communities and organizations that often don't hear about these opportunities. Because we really want those communities to have an opportunity to submit proposals that would be a part of this process.

So encourage whatever role you can play and that we can play in, you know, maybe going out to some of these places and sharing additional information about this project and/or, you know, leveraging our strategic planning work

groups and others who to some extent are maybe already engaged with these communities.

AC MEMBER RYAN: Can I make one more comment?

DR. NOLFO: Go ahead.

AC MEMBER RYAN: Just building on what I said earlier.

DR. NOLFO: Announce yourself.

AC MEMBER RYAN: I'm sorry, Patty Ryan with CBHDA.

Building on what I said earlier. I think the training and technical assistance part of this is critical because if we do want to identify those practices that are promising and effective and help them be sustainable into the future, because of the ACA and the expansion of people who are eligible for Medi-Cal, getting these programs ready and able to bill through the county behavioral health or mental health plan for Medi-Cal is critical over the long term because that's the only we are going to be able to maximize our services to these populations.

Not everybody who is going to be served by these pilot projects is initially going to be eligible for Medi-Cal and they shouldn't have to be. But if we want to sustain it into the future I think it is important to get incorporated into the county system somehow so that we can bill and get more federal funds into the program in the long term.

DR. NOLFO: I'm getting a message that we are going to move on in the interest of time to the other site. I also see that we are joined by Dr. Sergio Gaxiola.

AC MEMBER AGUILAR-GAXIOLA: I'm sorry that I'm really late.

DR. NOLFO: That's okay. Thank you.

AC MEMBER AGUILAR-GAXIOLA: Thank you.

DR. NOLFO: So Sandi, which site would you like to go to?

And then we'll come back for public comment after the advisory committee members have had a chance to discuss.

AC CO-CHAIR GÁLVEZ: Let me check here at the Oakland site. Does anybody want to make any comments?

Okay, nobody here needs to make any comments. Let's move to the San Francisco site.

And just to let folks know, we are about 15 minutes over already on this part of the agenda and we still need to have public comment so please keep your comments brief.

San Francisco site, anybody want to make any comment or questions?

AC MEMBER LU: Yes, this is Francis Lu. I just would like to reiterate what Pat had mentioned about sustainability as one of the criteria to look at in terms of evaluating a pilot project. I think that that seems so

important, that these projects do have a possibility of ongoing funding.

The other thing I would like to mention is on the table with the -- "culturally sensitive" was mentioned in the far left column twice. And I would like to suggest that we change the term to "cultural competence" because cultural sensitivity is only one aspect of cultural competence, which includes cultural responsiveness.

SAMHSA just put out a new treatment improvement protocol called Improving Cultural Competence and I did e-mail that information to Tamu and Jahmal for their consideration for dissemination to the advisory committee. Thank you.

AC CO-CHAIR GÁLVEZ: Any other comments from the San Francisco site?

Thank you. Los Angeles, you're next.

AC MEMBER RAMOS: This is Diana Ramos. And I just wanted to also reiterate and emphasize the importance of the sustainability. And perhaps when the RFPs are evaluated to really take into consideration programs that are going to be sustainable beyond the funding. Because we oftentimes find that programs are begun and then they're finished as soon as the grant is over; so again highlighting that.

AC CO-CHAIR GÁLVEZ: Are there any other comments or questions in Los Angeles?

AC MEMBER JOHNSON: No.

AC CO-CHAIR GÁLVEZ: Thank you. Fresno.

AC MEMBER NEWEL: It is all very exciting. I think I have no questions and no comments, thank you.

AC CO-CHAIR GÁLVEZ: Thank you.

So now I'd like to invite any members of the public that would like to comment on this part of the agenda. Operator, if you could please give the instructions again of what anybody calling in remotely would like to do. And in the meantime I will roll call each site to see if any members of the public at any of the sites would like to provide questions or comments, starting with Sacramento.

DR. NOLFO: Are there any members of the public who would like to comment on this agenda item?

THE OPERATOR: Yes. If you would like to ask a question please press *1 and record your first and last name clearly when prompted. Your name is required to introduce your question. To withdraw your question you may press *2. Once again, If you would like to ask a question please press *1.

DR. NOLFO: And I would actually like to say that per Bagley-Keene, if you don't want to give your name as a member of the public you don't have to. So you're welcome to say that to the operator as well.

Okay. And so we don't have anyone here in

Sacramento who would like to comment on this particular agenda item. You're welcome to move on to another site, Sandi.

AC CO-CHAIR GÁLVEZ: Thank you.

Oakland, would any members of the public like to comment?

MS. BUTLER: This is Dalila Butler with PolicyLink. And I just wanted to say I was really encouraged to hear about the funding opportunities and the flexibility around the agencies, the organization that could be funded. I think particularly because of the five, based on the ethnic focus groups that were mentioned, a lot of our work around boys and men of color has shown that especially programs that focus on healing trauma and addressing chronic adverse conditions has really been an area of exploration, further exploration. And there are a lot of groups like Youth Alive or National Compadres Network that has really started to address those things that might not have been seen as traditional mental health programs before so I'm really encouraged by the funding and just wanted to congratulate you all for the work you have done so far. Thank you.

AC CO-CHAIR GÁLVEZ: Okay, let's move to the San Francisco site. Are there any members of the public there that would like to make a comment or a question?

AC MEMBER GOMEZ: No, thanks.

AC CO-CHAIR GÁLVEZ: Thank you.

Los Angeles?

AC MEMBER JOHNSON: No.

AC CO-CHAIR GÁLVEZ: And Gail, was anybody present in Fresno?

AC MEMBER NEWEL: No.

AC CO-CHAIR GÁLVEZ: Okay, thank you.

All right. Well thank you, Jahmal, Tamu and Aimee for that update.

DR. NOLFO: It looks like we have a member of the public, Ricardo Moncrief, who would like to make a comment. Is that correct, Operator?

THE OPERATOR: Yes. Mr. Moncrief, your line is open.

MR. MONCRIEF: Okay, thank you. We are a small community up in Marin County. Jahmal has visited us.

And we are doing some really advanced work on infrastructure building. You know, particularly -- it happens that it has the government, a federally qualified health center, community and schools activities, a multi-disciplinary team all within walking distance of each other.

And we are setting ourselves up to be driven by a concept that came out of Stanford called Collective Impact, which allows us, you know, to coordinate all these

particular entities so get to the point of using -- this process by, you know, good, innovative and best practice mental health practices and whatnot.

I am just concerned that being a small community, we want to be factored into being, you know, a pilot program because we can get a lot of things done being small. But how does that impact your larger or how do we integrate some of the stuff into your larger communities that, you know, that can have a much more advanced lobbying force and they can get things done more directly than smaller communities. I just want to be able to be considered into that, into that mix.

DR. NOLFO: Thank you.

So Sandi, it doesn't look like there are any other members of the public waiting to speak on the line. It's up to you what you might like to do with the agenda. We do have a quorum. Sandi, have you muted your line? We can't hear you if you're talking.

AC CO-CHAIR GÁLVEZ: Hello?

DR. NOLFO: We can hear you now.

AC CO-CHAIR GÁLVEZ: Okay, great. Sorry, we got disconnected, we are back on now. Were there any other public comments that wanted to be made?

DR. NOLFO: It doesn't look like it.

AC CO-CHAIR GÁLVEZ: Okay, all right. Well thank

you everyone. Hopefully we'll not get disconnected again. That's our second time getting disconnected.

So now that we do have a quorum we are going to move back to the beginning part of the agenda where we did require a quorum in order to be able to vote on several items.

The first item is the approval of our May 12th and 13th Meeting Minutes. I am going to take the Chair's prerogative and start with my comments that I have on it.

As I was reviewing them I did notice that in the section of the minutes where we referred to the discussion around the bylaws section we need to have more clarity about which Roman numeral of the bylaws we are referring to because there are various Section Gs and Section Es and such. So they need to be amended to refer to the Roman numeral part of the bylaws as well.

DR. NOLFO: Thank you.

AC CO-CHAIR GÁLVEZ: That was the correction that I saw that needed to be made.

Are there any other comments on the minutes? I'll start here in Oakland. Any other comments? Anything on the minutes?

All right. Sacramento?

DR. NOLFO: Do any advisory committee members have comments about the May meeting minutes?

No, there aren't any here, Sandi.

AC CO-CHAIR GÁLVEZ: Thank you.

Los Angeles?

AC MEMBER JOHNSON: No, no comments.

AC CO-CHAIR GÁLVEZ: Thank you.

San Francisco?

AC MEMBER GOMEZ: No comments.

AC CO-CHAIR GÁLVEZ: Thank you.

Fresno?

AC MEMBER NEWEL: No comments.

AC CO-CHAIR GÁLVEZ: Thank you.

Are there any members of the public that would like to make any comments or questions regarding the minutes? Starting here in Oakland.

No comments. San Francisco?

AC MEMBER GOMEZ: No.

AC CO-CHAIR GÁLVEZ: Sacramento?

DR. NOLFO: Any members of the public who would like to comment on the May meeting minutes?

No, not here.

AC CO-CHAIR GÁLVEZ: Los Angeles, are there any members of the public that would like to comment on the meeting minutes from May 12th and 13th?

AC MEMBER JOHNSON: No comments.

AC CO-CHAIR GÁLVEZ: Okay. And there aren't any

folks in Fresno.

Okay, so with that I'd like to entertain a motion regarding the minutes. Would anyone like to make a motion?

DR. NOLFO: We may want to ask, Sandi, about folks who are on the phone, members of the public who are on the phone.

AC CO-CHAIR GÁLVEZ: Yes, I'm sorry, thank you for reminding me.

Are there any folks on the phone that would like to make a comment on the minutes from last meeting. I believe you need to press *1 and identify yourself.

THE OPERATOR: Yes. As a reminder, if anyone would like to make a comment you may press *1 on your touch tone phone. Please unmute your phone and record your first and last name clearly when prompted. And if you need to withdraw your comment please press *2.

One moment to see if there are any comments from the phone.

AC CO-CHAIR GÁLVEZ: Okay, I'm going to take it that there are no comments.

So would anybody like to make a motion regarding the minutes?

AC MEMBER GARZA: This is Álvaro Garza. I move we accept the minutes, pending the corrections that you mentioned.

AC MEMBER LOUIE: Second.

AC CO-CHAIR GÁLVEZ: Okay. I believe per our amended bylaws we don't need to make a second. I guess I have to do a roll call; is that correct, Tamu, for any votes of the phone meeting?

DR. NOLFO: Yes, that's right.

AC CO-CHAIR GÁLVEZ: All right. Does staff there actually have the correct list of who is at every site because I don't have the list. So if someone there could actually do the roll call I would appreciate it.

DR. NOLFO: Yes, I'm happy to do it. Sandi?

AC CO-CHAIR GÁLVEZ: Yes.

DR. NOLFO: Okay. Sergio?

AC MEMBER AGUILAR-GAXIOLA: Aye.

DR. NOLFO: Jeremy?

AC MEMBER CANTOR: Here.

DR. NOLFO: Yes?

AC MEMBER CANTOR: Aye. Yes.

DR. NOLFO: Yvonna?

AC MEMBER CÁZARES: Aye.

DR. NOLFO: Álvaro?

AC MEMBER GARZA: Yes.

DR. NOLFO: Cynthia?

AC MEMBER GOMEZ: Yes.

DR. NOLFO: Willie Graham actually had to leave.

Carrie?

AC MEMBER JOHNSON: Yes.

DR. NOLFO: Neal?

AC MEMBER KOHATSU: I was wondering, since I wasn't there and can't -- if I should abstain.

DR. NOLFO: Abstain, sure.

Dexter?

AC MEMBER LOUIE: Yes.

DR. NOLFO: Francis?

AC MEMBER LU: Yes.

DR. NOLFO: Gail?

AC MEMBER NEWEL: Yes. I said yes already though.

(Laughter.)

DR. NOLFO: Okay. Teresa?

AC MEMBER OGAN: Yes.

DR. NOLFO: Hermia?

AC MEMBER PARKS: Yes.

DR. NOLFO: Diana?

AC MEMBER RAMOS: Yes.

DR. NOLFO: Patricia?

AC MEMBER RYAN: Yes.

DR. NOLFO: Linda?

AC MEMBER WHEATON: Yes.

DR. NOLFO: Ellen?

AC MEMBER WU: Yes.

DR. NOLFO: There you have it.

AC CO-CHAIR GÁLVEZ: All right, thank you, motion passes.

So the next item on our agenda is the consideration of our bylaws. To review with folks, we did have a pretty lengthy conversation and I believe reached, you know, a lot of consensus. You know, we decided -- we used a process to reach consensus on all the different items that were brought up in regards to the bylaws and I am going to review those with you very quickly.

So the first, the first change to the bylaws was made on page 4 in Section -- what is it -- Section II-E: Office of Health Equity Advisory Committee Subcommittees. We decided to keep the language as it is, saying that subcommittees are comprised of voting members but that we can invite members of the public to participate and contribute as non-voting advisors.

We also -- if you go to Section III-B, Voting Rights. We did clarify that when we had teleconference-compliant meetings, members of the advisory committee could participate at publicly noticed locations.

Section III-G: Manner of Voting. Clarified that voting on elections shall be by a show of hands.

Otherwise, motions and resolutions shall be by a voice vote; and that if necessary, either the Chair or any

advisory committee member could request a roll call or a show of hands and the Chair would honor that request.

In the following section, Section H, we agreed that we would keep the rules to say that the meetings would be conducted by any accepted rules of procedure. And, you know, if at some point we want to change the current rules we can change them.

And those were the changes that we discussed and agreed to at the last meeting and all those changes are reflected in the bylaws.

So I guess I want to invite if there's any other changes on comments that people would like to make and have not. Hopefully we can finally approve these and have our official bylaws.

So I will start here with the Oakland site. Is there anybody that would like to make any comments?

Okay, we have none here.

Moving to the San Francisco office, are there any comments or changes requested there?

AC MEMBER GOMEZ: I have none. No, we have no comments here.

AC CO-CHAIR GÁLVEZ: Wonderful.

Sacramento, any comments or suggestions made there?

DR. NOLFO: Álvaro Garza.

AC MEMBER GARZA: Yes, thank you. I am fine with the changes. I did -- after the meeting I did submit some e-mail suggestion and I believe it doesn't have to be for the bylaws. But the suggestion was, on page 2 regarding the Rules and Responsibilities for Members is to consider a similar role and responsibility for the Office of Health Equity to be the staff. So it is an equitable relationship, if you will, we have roles and responsibilities to each other. And it may not be appropriate for the bylaws so I don't think it has to be in there but I don't want to lose the idea, the concept, and maybe we can approach that or discuss that in another way and do it in a different way.

OHE DEPUTY DIRECTOR MILLER: Okay.

AC MEMBER GARZA: But I am fine with the bylaws.

AC CO-CHAIR GÁLVEZ: Okay, perhaps at a future meeting we can review what the statute says regarding this and see if there is any clarification that we would like to ask the staff or suggestions of what we would like the Roles and Responsibilities to be of staff for the advisory committee.

Any other comments in Sacramento?

DR. NOLFO: No other comments here.

AC CO-CHAIR GÁLVEZ: Okay, Fresno.

AC MEMBER NEWEL: Nothing out here.

AC CO-CHAIR GÁLVEZ: Los Angeles?

AC MEMBER JOHNSON: No.

AC CO-CHAIR GÁLVEZ: Okay. So with that I'd like to entertain a motion.

DR. NOLFO: Public comment.

AC CO-CHAIR GÁLVEZ: Sorry, public comment, I'm sorry. So Oakland, any comment on the bylaws? Any comments from the members of the public here?

No comments.

Fresno? Fresno doesn't have anybody present.

Los Angeles?

AC MEMBER JOHNSON: No.

AC CO-CHAIR GÁLVEZ: San Francisco?

AC MEMBER GOMEZ: We actually don't have anyone from the public here.

AC CO-CHAIR GÁLVEZ: In San Francisco?

AC MEMBER GOMEZ: Yes, just for the future.

AC CO-CHAIR GÁLVEZ: Okay, thank you.

Sacramento?

DR. NOLFO: Any members of the public want to speak to the bylaws?

No, not here. Check the phone lines.

AC CO-CHAIR GÁLVEZ: Okay, on the phone. Would anybody on the phone like to make a comment regarding the bylaws? If you do please press *1 and identify yourself.

Okay, I'll take that as no comment.

So with that I would like to entertain a motion.
AC MEMBER GARZA: I move we accept the bylaws.
AC CO-CHAIR GÁLVEZ: Thank you.
Okay, yes, can you please do a roll call?
DR. NOLFO: Sure. Okay, I'll start with you. Sandi?
AC CO-CHAIR GÁLVEZ: Yes.
DR. NOLFO: Sergio?
AC MEMBER AGUILAR-GAXIOLA: Yes.
DR. NOLFO: Jeremy?
AC MEMBER CANTOR: Yes.
DR. NOLFO: Yvonna?
AC MEMBER CÁZARES: Yes.
DR. NOLFO: Álvaro?
AC MEMBER GARZA: Yes.
DR. NOLFO: Cynthia?
AC MEMBER GOMEZ: Yes.
DR. NOLFO: Carrie?
AC MEMBER JOHNSON: Yes.
DR. NOLFO: Neal?
AC MEMBER KOHATSU: Yes.
DR. NOLFO: Dexter?
AC MEMBER LOUIE: Yes.
DR. NOLFO: Francis?
AC MEMBER LU: Yes.

DR. NOLFO: Gail?
AC MEMBER NEWEL: Yes.
DR. NOLFO: Teresa?
AC MEMBER OGAN: Yes.
DR. NOLFO: Hermia?
AC MEMBER PARKS: Yes.
DR. NOLFO: Diana?
AC MEMBER RAMOS: Yes.
DR. NOLFO: Patricia?
AC MEMBER RYAN: Yes.
DR. NOLFO: Linda?
AC MEMBER WHEATON: Yes.
DR. NOLFO: Ellen?
AC MEMBER WU: Yes.
DR. NOLFO: And that's all.
AC CO-CHAIR GÁLVEZ: Okay, thank you. So the motion passes unanimously. Congratulations, we finally have our bylaws.

And Tamu, I think that you have Gail on your list twice so for future voting if you could take note of that.

Okay, so the third item that we need to discuss is regarding our staggered membership terms. We are the first advisory committee and per the statute we are to have staggered terms so we do need to have a discussion about how we would like to -- the decision is within the Office of

Health Equity, we are only to give advice. Jahmal, would you like to discuss this a little bit and your ideas for how to move forward with this?

OHE DEPUTY DIRECTOR MILLER: Yes. One of the things that Tamu -- Tamu and I have both talked about this and we'll both have comment on this. When I first joined and kind of did an assessment on the existing composition of a strong advisory committee and I really applaud the effort and the criteria by which the members were selected. But in addition to assessing and evaluating who we have I immediately thought about who don't we have with respect to kind of a gap analysis, that we haven't officially done.

But I think moving forward as we ultimately determine how we move forward with the staggered approach to having sustainability, kind of the institutional knowledge sharing from one transition to the next, I ultimately want to ensure that we factor in in the future, you know, other important stakeholders that we want to have at the table as we, not just implement our health equity statewide plan but ensuring that we are adequately adhering to our mandate.

So I think there is an opportunity to diversify, not with respect to just the demographics but when we think about from a private/public/community-based perspective. Other voices that I think could be instrumental players at the table, whether it could be from organized medicine, it

could be from safety net entities, FQHCs, private foundations, major health systems and others that would kind of -- I've kind of made this list of ensuring that moving forward we have some representation at the advisory committee level. And that is the advantage we have of having a relatively larger than normal advisory committee.

And knowing that we can't perfectly do that. I think as we -- ultimately what we are going to talk about, kind of the subcommittee next steps of how we will evolve as a committee. There could be opportunities even there when we think about the gap analysis at the advisory committee level of how we can ensure that we are engaging key stakeholders who may not be represented at the health equity advisory committee level.

So from a visionary perspective that is kind of what I see. And Tamu and I talked a little bit more in detail about from a composition standpoint and from a logistics and technical perspective how we move forward on that. Do you want to comment on that?

DR. NOLFO: Sure. So what we are thinking in terms of staggering is that essentially a third of the current advisory committee would be expected to roll off a year from now. So a third of the advisory committee would be on for two years, a third would be on for three years, a third would be on for four years. And so what that means is

that we need to start doing some planning and some thinking now about what that is going to look like and who that third is going to be, not only so that they can prepare, those of you can prepare to roll off, but also so that we can start thinking about who we are bringing on and what that process is going to look like.

So what we would like to do is to have folks volunteer. If you know that you want to be in that first cohort to roll off, to let us know that so we can take that into consideration. For whatever reason that may be.

What we will do is we'll then look at the balance, the difference. So let's say that we have a couple of people who know that for whatever reason they want to be in that first cohort to roll off and that would leave us with maybe about six other people. If I'm doing the math right, six or seven other people who would also be rolling off next September.

We'd essentially put everyone's names in a hat, draw names. Jahmal would take a look at them to look at whether or not the balance, the composition of the advisory committee would really be maintained, especially with some of the key relationships that we have in our statute like with HIAP and Department of Health Care Services and whatnot. So that we can see whether it makes sense for those folks who are pulled out of the hat really to roll off

next September. And then we could make some decisions from there moving forward.

So I am not sure at this point if people want to give it some thought and get back to us over the next couple of weeks. To simply send me an e-mail to let me know if that is something that you'd want, that you want your name to be considered for that first cohort to roll off.

And if I don't get any responses from advisory committee members I will assume that everyone is very happy being on the advisory committee and would willingly step up to their responsibilities for another two or three years and then we'll just go ahead and put everyone's names in a hat and go from there. But we should be able to report back at the December 12th meeting where we stand with this process.

So I can open that up to discussion at the different sites. It looks like we have a comment here in Sacramento from Dexter Louie.

AC MEMBER LOUIE: Just clarification on your comment versus on page 2, number 7. The way I read number 7 there are two groups, two cohorts; 12 or 13 with a two-year term and the balance having a three-year term. That's the way I read it. I didn't see a three cohort --

DR. NOLFO: You're absolutely right. So the other two thirds would actually be looking at serving a three-year term as opposed to a four-year term.

AC MEMBER LOUIE: Right. And then if I might continue that. In my experience, trying to do cohorts is virtually impossible because people resign in the middle, they have personal issues. You just really fill as best you can the gaps that you identify. And actually it looks from this, people could actually serve up to nine years.

DR. NOLFO: And I think that maybe was some of the thinking when I had originally read this was that we would start with the first year or the first term rather, the first two year term, and kind of take it from there and see what made sense after that. Because it would really be up to Jahmal's discretion in terms of seeing whether we have the right nix of people, whether we needed to further diversify, whether we needed to grow the advisory committee. But to be able to start with the first round of two-year terms. Are there -- Yes, Pat Ryan.

AC MEMBER RYAN: So just to clarify because that was my understanding too. That even if -- You know, I know you have staggered terms. But if somebody indicated that they were interested -- like let's say I was a two year. If I were interested in continuing on then that could be thrown into the mix for consideration, so you don't necessarily just roll off. But you don't necessarily automatically stay on either.

DR. NOLFO: Correct. Álvaro Garza.

AC MEMBER GARZA: Yes, I was going to mention what Dexter did. One other thing, unless you did mention it and I didn't hear it, is that the terms shall be selected randomly.

DR. NOLFO: Right. Which is the whole names in the hat thing.

AC MEMBER GARZA: Okay, got it.

DR. NOLFO: Do we want to move to another site or are there other advisory committee members in the Sacramento site that want to comment?

So Sandi, if you want to move to another site for advisory committee member discussion.

AC CO-CHAIR GÁLVEZ: Okay. San Francisco, anybody there want to make a comment on this or a question?

AC MEMBER GOMEZ: Yes, this is Cynthia. I guess I would say that I have seen the cohort mechanism work extremely well, you know. And some of that is, yes sure, folks may voluntarily have to leave and therefore that cohort has to add an additional member that particular year but I think it makes total sense for the sustainability in bringing new blood on the council, so I support the notion.

I just want to be clear that the terms would begin in September; is that correct? So people now, if you volunteered to rotate off you would be on board until August 30th of 2016 -- '15, I mean?

DR. NOLFO: Yes, that is my understanding, Cynthia.

AC MEMBER GOMEZ: Okay, thanks.

MS. BEN-MOSHE: That's it in San Francisco.

AC CO-CHAIR GÁLVEZ: Okay. Los Angeles?

AC MEMBER JOHNSON: No.

AC CO-CHAIR GÁLVEZ: Fresno?

AC MEMBER NEWEL: No comments.

AC CO-CHAIR GÁLVEZ: Here in Oakland?

I will make a clarification comment. I believe from reading the bylaws that we would be able to serve up to six years, not nine. It says we can be -- number 9 says that we can be considered for reappointment for one additional three year term.

AC CO-CHAIR GÁLVEZ: Okay, so I'll open it up to the public. Are there any comments around this topic? I'll start here in Oakland. Any members of the public who would like to comment on this?

Okay, San Francisco doesn't have anybody.

Los Angeles?

AC MEMBER JOHNSON: No.

AC CO-CHAIR GÁLVEZ: Sacramento?

DR. NOLFO: Any members of the public want to comment? No.

AC CO-CHAIR GÁLVEZ: Okay. And on the phone. If

anybody on the phone would like to comment on this please press *1 and identify yourself, if you would like to.

Okay.

DR. NOLFO: Dexter Louie does have a comment.

AC CO-CHAIR GÁLVEZ: I'm sorry, someone does?

DR. NOLFO: Dexter Louie.

AC MEMBER LOUIE: I have a question and it's really to our attorney advisor. That last comment is that someone said it would be six years and I read 8 and 9 as being two separate three year terms. So I'm not sure whether 8 and 9 are in conflict or one supersedes another, I don't know. The plain reading of it sounds like there is one reappointment and then there can be another reappointment.

DR. NOLFO: Katie, do you want to weigh in on that?

MS. BELMONTE: I don't think -- I think our intent was just to have the ability for one reappointment.

AC CO-CHAIR GÁLVEZ: I'm sorry, could you please get closer to the mic, we can't hear you.

DR. NOLFO: This is Katie Belmonte, our legal --

MS. BELMONTE: This is Katie Belmonte with CDPH. I think the intent was to have two terms. The standard term -- well, for this first group we are going to stagger them with a portion being two years for the initial term and

a portion being three years and then they can subsequently be reappointed for another three year term.

For all future appointments we were going to start with just kind of the base three year term for everybody. But we did write some language in there still kind of allowing for the ability for the Director to still, you know, kind of toy with that three year term with necessary. So the standard term would be two or three years with the ability for reappointment for three years. However, up to the Director's discretion he can, you know, either make those terms less or more.

DR. NOLFO: That's ambiguous.

(Laughter.)

MS. BELMONTE: So perhaps that didn't --

AC CO-CHAIR GÁLVEZ: Could you differentiate between number 8 and number 9; 8 says "appointment" and 9 says "reappointment". So I think 8 refers to the initial appointment of someone and then number 9 --

MS. BELMONTE: Correct, that's correct.

AC CO-CHAIR GÁLVEZ: -- allows for the reappointment of someone for an additional three year term to their two or three year initial term.

MS. BELMONTE: What I meant by "all subsequent appointments" would be not this initial advisory committee that was appointed but for all subsequent committee

appointments after this initial 26-member.

AC CO-CHAIR GÁLVEZ: Okay. So I think that we're done with the comments. And although the agenda has that we would have a vote on this I don't see what there would be to vote on, given that this is not our call.

DR. NOLFO: Right. Okay, then we can move on. Do you want to direct us to where in the agenda you would like to go now, Sandi?

AC CO-CHAIR GÁLVEZ: Yes. So let's move then following the -- you know, going back to the original order. Next we'll have the presentation on the Health in All Policies Task Force Update from Julia and Linda.

DR. NOLFO: Thank you.

AC CO-CHAIR GÁLVEZ: There is a presentation, a PowerPoint presentation as part of this. So if you could please bring those up and remind speakers to let us know when you're moving from slide to slide. And also during the presentation if all sites could please mute themselves so that we don't get background noise during the presentation.

MS. CAPLAN: Great. Good morning, this is Julia Caplan. I wanted to just check. So Linda Wheaton, you're there in the Sacramento space; is that right?

AC MEMBER WHEATON: I am.

MS. CAPLAN: Great. And so, Linda, what you and I talked about and I want to go over this for everybody else

is that I am going to be -- I am going to do the overall presentation about the Health In All Policies Task Force but then I invite you to chime in at any point and I'll also give you a chance at the end for anything you want to add.

I am grateful for this opportunity to speak to all of you OHE advisory committee members and also all of our public folks. I really appreciate, especially the public, for making the time to be here today and be with us in different places and on the phone.

What I am going to do today is give you kind of -- I was asked to give an update on the Health in All Policies Task Force so that is what I am going to do.

I presented about the task force at a previous OHE advisory committee meeting so I am not going to do a long history of the task force but I am going to do a little bit of a reminder about the origins of the task force and its purpose, who is on it and what it says.

And then I am going to talk about the OHE's strategic plan. And what our team has done is actually gone through the plan and noted areas where the Health in All Policies Task Force is currently doing work that we see as being closely aligned with the OHE strategic plan. So I am going to walk through what those are.

And then I'm going to talk about the current work of the Health in All Policies Task Force, so what the

current priorities are. I'm going to highlight where this group is working right now, talk a bit about future work and where we're heading and then close by talking about some of the opportunities for the OHE advisory committee as well as other stakeholders to get involved with and support the Health in All Policies Task Force.

So let's move to the next slide. You should see in front of you a picture with a whole bunch of logos. So this slide is really just a reminder of who is on the task force. Now 22 agencies and departments. It's a big group, it's very diverse. We have a range of policy areas represented including transportation, education, social services and labor, food and agriculture, Cal-Fire, particularly their urban and community forestry programs, Parks. I am not going to name them all but I just want to kind of remind you all of the diversity of this group and the variety of perspectives that we have. It's just really, I think, one of the most exciting parts about this project.

So we'll go to the next slide. So this is really a reminder about the task force itself. The purpose of the task force is to promote health equity and sustainability. And the other real purpose of the task is to create alignment between departments and agencies across government to reduce redundancies, increase efficiency and really to find opportunities to do work to promote health equity and

sustainability. To find areas where maybe no one department could actually achieve certain goals -- any of those working alone -- but through the task force we can create collaborative opportunities and foster some new directions in terms of work. And so that's really the goal.

As a reminder also, this is the first task force like this in the country so we're breaking new ground. It's exciting and interesting and there is no road map so we are figuring it out as we go along.

We are four years in, which means we have actually figured out quite a bit but every day is new and so we are always kind of interested in hearing ideas and getting input. It's really an exploratory process and creative process, which I think has made it very valuable for the participants.

The task force was created through a Governor's Executive Order; it was then reinforced through a Senate Concurrent Resolution.

An important feature of this task force is that it reports to the Strategic Growth Council. The Strategic Growth Council is a cabinet-level body that was also created by Governor Schwarzenegger that is charged with environmental sustainability. And so we have an interesting lens to our work where we are always looking at the relationship between promoting health and promoting

environmental sustainability; and we really have to keep those two pieces hand in hand.

The funding for this project is coming from the Department of Public Health, the California Endowment and Kaiser Permanente Community Benefit.

And the process is facilitated by the Department of Public Health with also staffing from the Public Health Institute.

It's a consensus process. We focus on co-benefits.

And it's important to mention that -- where I mentioned that there was funding, that funding supports the backbone or the facilitation team but the departments themselves do not receive additional funding for this. So their participation is really voluntary, it's on top of all of the other work that they do. And the result of that has been very important for us to identify directions and areas of work that really meet the needs of all of the partners on the task force. The task force gathers input in terms of where it should work but makes its own decisions and sets its own agenda.

So move to the next slide. And here I am going to talk about -- the next three slides I am going to talk about the OHE strategic plan and where there is overlap.

We called out a number of the goals in the

strategic plan that I wanted to talk about. The first one here, CHP stands for Communications Health Partners. And I know Jahmal and Ron Chapman mentioned earlier that the strategic plan is not finalized and it is not out yet, but we are anticipating that these pieces will be in when it does come out.

So one of the goals is to facilitate common understanding of health and mental health equity and the social determinants of health between potential health partner agencies and organizations. And the term "health partner agencies" is really in this case meaning non-traditional partners, the partners that often are not thought of as health institutions, but do a lot of work that shapes the health of our environment.

So the task force's simple existence is actually supporting this. So the quarterly meetings of the task force, the entire process of the task force.

And then in addition the task force is going to be launching a collaborative learning series over the next year specifically on health equity and social determinants of health.

We are doing a lot around this, we are not doing everything that needs to be done, it's really just one piece, but I wanted to call that out.

I'm going to go to the next slide. And this one,

IHP1.1, it stands for Infrastructure Health Partners. And this goal in the strategic plan is around embedding health and mental health equity criteria into things that government does; so decision-making grant programs, guidance documents, strategic plans.

This also is very big for us in the work of the Health in All Policies Task Force and so I've listed a number of examples of where the task force is doing this work and will be doing this work over the next couple of years.

The first top two are grant-making programs. One of them is around transportation and the other is around the affordable housing and sustainable community grants. And the Health in All Policies team as well as many members of the task force have been involved in developing the grant-making guidelines for these programs and have been or will be involved in reviewing grants. As well as subsequently doing their review of how the process went and gathering lessons learned to really shaping that process.

The next two, the California Transportation Commission Regional Transportation Guidelines and also the General Plan Guidelines, these are two major land use spanning guidelines that are issued by the state that shape very big decisions at a local and regional level around transportation and land use.

When the Health in All Policies Task Force held public workshops in 2010 and we went around the state and we asked people, "What are you trying to do in your communities and what could the state do to help?" These were two things that we heard over and over again. It would be a really, really big deal if we can work with these two sets of guidelines, the Transportation Guidelines and the General Plan Guidelines, and do more to embed health equity into the guidelines.

And in fact, that is happening right now. The General Plan Guidelines, the Office of Planning and Research is going to release a draft guidelines later this year and we hope that you all will be -- get involved in giving input. And the Transportation Guidelines are going to come open for review next year.

And we have secured through Health in All Policies a commitment from our state transportation leadership to make health equity a priority in that process. And I should credit Ellen Wu who is sitting at the table with me who actually has been one of the proponents really leading the charge around that for several years, even before the Health in All Policies Task Force was created.

I am going to go on to the next slide. And CB1&2.2. CB stands for capacity building. And this goal of the OHE strategic plan is really around workforce

development and developing the capacity of more people around health and mental health equity in the health workforce and in the broader workforce. And so the Health in All Policies team does this in a variety of ways. We provide informational interviews, we do a lot of coaching for graduate students, we hire graduate interns, we place interns with other departments that are doing Health in All Policies work and so I wanted to call that out.

We'll go to the next slide. So now I want to get into the current activities of the task force. And I already started to talk about the transportation guidelines.

We actually have had a very big push over the last year to Active Transportation. The idea of supporting people, more people to walk, bike and take public transit. This is for a variety of reasons including the nexus between -- active transportation is good for physical health and mental health. It also helps against greenhouse gas emissions and helps support the state's environmental sustainability goals.

And the task force has worked to put together a new action plan around that. Actually the first bullet up here -- I'm going to back up a little bit.

The first bullet up here is a report that the task force has created outlining what it has done over the last three years in this area.

And then the next bullet, it represents the action plan, which is a set of commitments that the task force has made for the next two and a half years, so a little over two years.

We spent nine months developing this plan. And the reason it has taken so long to develop is because we have gone very deep with many of the departments involved. So we have identified some pretty big ticket items in terms of commitment, the changes the departments are trying to make. And also identifying problems where we have six or seven departments facing the same issue and forming multi-agency working groups to move that work forward.

And this plan is going to be presented to the Strategic Growth Council on Monday, next Monday, October 6, so it has just been posted to the public. I can make sure that you all have a link to it and can view it. And it will be presented at the Strategic Growth Council, which is a public meeting. The public is invited to participate in person in Sacramento and can also view the meeting on-line and can provide comments that way. So I encourage you to attend and get involved.

I am going to go to the next slide where it says "Key themes" in blue. And I want to say just a little bit more about the active transportation work. We really see safety as a key part of this. So if we are going to have

more people walking and biking we are also going to have more people getting hit by cars. And that's a reality and it is something we have to take really seriously.

And in fact, low-income communities and communities of color already have more people walking and biking and also tend to have much worse infrastructure in terms of safety features and so those are the communities that are already impacted the most by safety issues.

And so safety itself is an important equity issue and is a big piece of this plan. Because actually when we are talking about increasing walking and biking we are talking about safe walking and biking and talking about safe walking and biking and talking about what more can we do around safety.

In fact, we have had a couple of departments that are not on the task force that signed up to help with this. One of those is the Department of Motor Vehicles, which is looking into how to improve information that it gives to vehicle drivers on bikes and ped safety. And also the California Highway Patrol to be more around enforcement around safety. So that's something real exciting.

We also -- I am going to skip down. We have some significant commitments in here around school environments. And the Department of Education is involved as well as the State Architect, which influences quite a lot around how

schools are designed. They are working closely with our Office of Planning and Research and our transportation folks to figure out how to create better alignment between all of these different land use processes.

And the last bullet here around data and measurable goals. This has been an interesting item. We found that a lot of people want to increase walking and biking to school but it turns out that there is no way right now. There is no system in place to aggregate data to be able to know across the state how are kids getting to school and be able to make comparisons over time. And so we have got a variety of departments coming together to form a multi-agency work group to tackle this issue and also to establish a statewide goal, a cross-agency goal of what we call a mode-shift, which is shifting transportation modes. So it's getting more people out of their cars. At this point there is no statewide goal but the transportation agency has taken leadership on pulling this group together to establish that so we are really excited.

Go to the next slide. This is future directions of the task force. So we spent a lot of time on active transportation. We are going to continue to spend a lot of time on it over the next couple of years because we have a great window of opportunity.

But we are also going to be opening up an

exploratory process around violence prevention really asking a couple of questions. One is, "What is the state's role in violence prevention?" So much of this work happens locally so what is the role of the state? But specifically, "What role can the task force play?" What is the unique perspective that can come from having 22 different departments and agencies interested.

Violence prevention is really key because -- I mean, I think we all know the importance of violence prevention for health and for mental health. But it actually impacts every department that we work with, whether it's education or social services or transportation or parks. And I could go on so it's really a universal theme.

We will also be doing more exploratory work around access to healthy food. We now have a state Farm-to-Fork office that will be involved in supporting that offense and gathering input around where that office does its work.

Also looking at community greening, particularly bringing an equity lens to community greening.

And then as I mentioned, the health equity in learning series.

And I'm going to go to the next slide. Opportunities. So this is the place where we talk about your role as OHE advisory committee members and also the public. I think a very important role for you all is to

help mobilize input and give us input in these processes.

Some of that input goes to us, the Health in All Policies staff and task force, and some of it goes to the departments we are working with. So the General Plan Guidelines Update, the Transportation Guidelines and also the California Transportation Plan 2040, these are all major planning documents at the state level that have big impacts on where dollars go and where we have an opening to really bring a health and equity lens. And there will be opportunities, significant opportunities for public input. And so we'd like you all to not just weigh in yourselves but to also invite your communities to participate in this process. Part of that means helping communities learn what these processes are and how that works and that is something that we will be strategizing around.

And then the other is provide input to our staff team, specifically on these questions around violence prevention, community greening and access to healthy food. And I can do some strategizing with Sandi around what that might look like but maybe we can set up a conference call or some sort of format to gather input from AC members that are interested.

So this is -- I am going to the last slide now. That wraps up my presentation. I think at this point I want to invite Linda Wheaton and also Jahmal and see if either of

you have anything you want to add?

AC MEMBER WHEATON: Well I just want to say I think, Jill, you did a good job of kind of -- of giving an overview of the task force. It is, I would say, quite challenging to work in this forum with a state agency without dedicated resources. And so we, from time to time, depending on what we are responsible for, some times are more challenging than others and especially recently we have been working on the cap and trade program, including representatives from the CDPH.

I might just a clarification that affordable housing and sustainable communities, greenhouse gas reduction program, is not just a grant program but it is also a loan program. So one of the challenges here, you saw a lot of what we are talking about is having input into guidelines, but it's -- there are significant differences when you are dealing with guidelines and plans, vis-a-vis real estate development projects. Which this program does both of those and it brings together, brings together a lot of repeating policy objectives. The most significant of which is reduction of greenhouse gases, and something that none of our state programs have had to deal with before in actual development from the ground.

So the first time we are going through this when we are talking about projects that have already received

their entitlements, vis-a-vis the contrast with what we might expect going forward in the future, are things that we both have to take into consideration.

So the active -- the implementation. This is a key period for the active transportation implementation program. As you said, they have spent a significant amount of time going deeper on this and this is -- you know, we have come of the culmination with the state's redesign of the active transportation program and grants that were awarded by the CTC recently and those will be building out in the next -- over the next year or so.

Combined with a focus on active transportation within the affordable housing and sustainable communities program, for example, those projects paired with other projects. And a lot of emphasis at the local level, regional level, on building out of bike paths, first mile/last mile strategies with regional transportation plans. And I know many of the health folks have been very active in a lot of those programs heretofore so I think this is a critical implementation period coming up.

Other than that I welcome any questions you might have.

MS. CAPLAN: This is Julia. I just wanted to mention that on the last slide, the link for the Health in All Policies Task Force is not correct, that URL has

changed. And so we'll make sure that an e-mail goes out after this meeting that provides the correct link and also gives you a link to the Strategic Growth Council, Health in All Policies active transportation work.

AC MEMBER WHEATON: There is one more thing I might add relative to the reference on the California Transportation Plan coming up. We are also involved in the -- preceding that, with input into that, is the California Bright Plan, which includes a community and environmental health chapter and focus on community impact. So we are anticipating strategies within that that would feed into the overall transportation plan that would eventually involve the public health sector and community activism around mitigation.

OHE DEPUTY DIRECTOR MILLER: I'll make my comments very brief, just three quick comments.

I really appreciate the co-benefits that we have experienced in the office of having the HiAP infrastructure in place. When were asked by Agency and the Department of Finance to kind of go back and collaboratively engage with other departments and offices on reviewing our demographic analysis or disparities report, having those existing relationships with these departments, offices and agencies that typically, you know, a government entity would not even work with. Having HiAP already in existence and being able

to quickly turn around this review process was a huge benefit to us. That's one comment.

Two, I applaud the efforts around -- that have currently been shared around transportation and the future benefits we anticipate from that. But I also appreciate the conscious effort of looking forward as to what some of the future opportunities are around, you know, really more consciously talking about the integration of equity. And I think violence, community greening and really talking more about the mental health implications of this work and the training and development opportunity, particularly across state government, is going to be really important so I appreciate the partnership and the work that has been done.

And I think with the future focus areas when we think about violence, community greening and others, it allows us to integrate other partners that may or may not have been involved but come to HiAP. When we think about the MOC, we think about mental health stakeholders. The next frontier really is going to allow some of those partners to get more involved. So applaud you for those efforts. Those are my comments.

AC MEMBER AGUILAR-GAXIOLA: I have a comment as well.

DR. NOLFO: It looks like we have Sergio who would like to make a comment, Sandi.

AC MEMBER AGUILAR-GAXIOLA: Yes, two comments, Julia and also Linda. Excuse me, sorry, Linda.

MS. CAPLAN: Speak up so I can hear you guys.

AC MEMBER AGUILAR-GAXIOLA: Okay. One comment is that in one of your slides you have -- one of the slides you mention that the task force is aligned with the OHE strategic plan and the CDPH strategic plan and also some guidelines and reports. And my question is, if you have a document or something that can inform us as to where in those documents, you know, the Health in All Policies is included so we have a sense as to what is the -- what is the inclusion and the potential reach.

This Health in All Policies has been going around for many years. WHO started with this policy. And one of the reasons is the recognition that access to health care, quality health care is not enough. That in order for populations to keep healthy and to avoid premature death we need to pay attention to social determinants of health, and therefore the inter-sectoral collaboration is of critical importance.

Given that, I think that it would be a good -- I am glad to hear Jahmal of one specific example of how you experience, you know, the work that the Health in All Policies has helped you, you know, to have access and easier access to other sectors. But I think that the big challenge

here is, is there a way to measure what is the impact really, on population health? Of having a policy like this. Which makes a lot of sense.

OHE DEPUTY DIRECTOR MILLER: Right.

AC MEMBER AGUILAR-GAXIOLA: But I think that the proof in the pudding is, you know, what is the impact.

AC MEMBER WHEATON: This is Julia, I would like to respond briefly. And I think brought up a lot of interesting points but I just want to respond to the last question of how do we measure the impact. It is really difficult to measure the impact of upstream changes on population health. And this is something that, you know, I am one of many, many people asking. You are one of many, many people asking that question.

What we are doing around the task force is a couple of things. One is that we are doing more to gather our stories right now and tell stories about the work, about the purpose of the work and then what actually happened.

And we are also -- in our active transportation plan we have actually created a -- I'm not sure if we are calling it a logic model but basically a visual diagram kind of showing the connection between the upstream work and ultimately how that affects communities.

But the other is that we are having ongoing conversations with evaluators and we are actually starting

to work with a Canadian researcher who is looking at about 15 international examples of Health in All Policies and is including us in his study and he is drawing out some of the success factors and impacts. That's one of our strategies is to team up with people who really have the expertise. But we definitely have a long ways to go in really measuring and demonstrating impacts. I appreciate you mentioning it.

DR. NOLFO: Neal Kohatsu has a comment.

AC MEMBER KOHATSU: I just want to support Sergio's call for evaluation. I think we all can appreciate how difficult it is. But I would say that just from the health care side, the policies that can do good can also do harm, so just a couple examples. Forest fire suppression was thought to be -- you should suppress every forest fire. That ended up to be a wrong policy, although well-intended. And many of us have experienced traffic calming, just in the area of transportation, and found out, whoops, the side effects actually were worse than the initial status.

So those are just two kind of simple-minded examples. But policies can actually do harm so we have to look and evaluate, not as a nicety but we have to acknowledge that it might not even be neutral, it might even be harmful. And so that's the importance of, again, recognizing the difficulty. But I think we have to commit to really looking at evaluation.

AC MEMBER AGUILAR-GAXIOLA: I have one more comment, I'm sorry.

DR. NOLFO: Sergio has another comment.

AC MEMBER AGUILAR-GAXIOLA: And that is related to violence prevention as it relates to health and mental health, especially mental health. There is an increasing body that has - and this is worldwide - the impact of experiencing violence early in life. The consequences in the early onset mental illness and the onset or the association with premature death and the starting of chronic health conditions. Actually what the literature strongly indicates is that the strongest predictor of early onset mental illness and premature aging and death is childhood adversities. So violence is of critical importance, not only violence but neglect as well. I think that is -- and poverty. Yes, poverty is very much.

I think that violence prevention sounds great but, you know, I wonder if you have thought about extending that, extending that to those who already experience violence, you know. Those who are experiencing violence. Which in the US a rough estimate is about one-out-of-four in the general population and I think that that's a gross undercount. The situation is even worse than that.

So anything about addressing those who already have experienced trauma or violence?

OHE DEPUTY DIRECTOR MILLER: This is Jahmal. I know we want to move on in time but I do want to add a brief comment on that.

HiAP will definitely play a critical role in their focus on the violence piece but we also have some other areas where we are engaged around the statewide adverse childhood experiences steering committee. And we also with the US Department of Justice have been included in the state's new policy initiative on defending childhood and not just evaluating the impact of violence on our communities, but really responding to them in an actionable way.

Those are just a few examples among others that we are kind of teeing up right now. The inter-agency task force Boys and Men of Color, once again, is going to be a way in which we explore those options. So we can connect off-line and identify where specifically we are tackling those areas; I'm on the same page with you.

AC MEMBER AGUILAR-GAXIOLA: That's good, thank you.

AC CO-CHAIR GÁLVEZ: Are there any other comments there at the Sacramento location?

DR. NOLFO: No, there are not.

AC CO-CHAIR GÁLVEZ: I'll bring it now here to our Oakland location. Any comments or questions?

Okay. I would like to explore a little bit how to

better integrate feedback from the advisory committee into the work of the task force. You know, there was a lot of information provided but I believe that one of the guidelines was going to be up for public discourse sometime later this year. Do you know if the public comment period will be the length of it or more or less when? Because I'm thinking that it's potential that we could overlap that with when our advisory committee meets again in December. Potentially have that be one of the items that we, that we actually discuss with the advisory committee. Not just as individual members but as a body can actually get a presentation on it and have the opportunity to provide some targeted discussion.

MS. CAPLAN: This is Julia Caplan. The general plan guidelines will probably be -- we are expecting that they will be open for a 90 day public comment period. But we don't yet know when they'll be released and I am guessing that they will be released in January.

AC CO-CHAIR GÁLVEZ: Okay. And the other one was later then? Because I remember you said one was later this year --

MS. CAPLAN: Yes. Transportation will be next year.

AC CO-CHAIR GÁLVEZ: Okay.

MS. CAPLAN: Probably not until next summer.

AC CO-CHAIR GÁLVEZ: Okay. But I do think that we need to look at the opportunities like that when there is a public comment period that falls in line with when we're meeting, it would be good for us to be able to as a committee look at some of these. Because I think that for all of us it would be -- I think some of us have been very involved in the Health in All Policies Task Force work and very observant of it and following it for years and for some of us on the committee I think it's newer. And I think increasing our overall understanding and our collaboration, given that it is in the statute and part of what this advisory committee is supposed to be doing, I think we need to look for opportunities for that.

Given that. You mentioned a couple of areas around violence prevention, healthy food access and urban greening that you would like to get feedback on. So maybe we can bring those items actually to the advisory committee meeting and have an opportunity to get -- because those are terms that not everybody necessarily is totally familiar with, what you would even mean by that, so I think it would be good to actually have those on a future agenda of ours and constantly be looking for opportunities like that.

Jeremy, you want to say something?

AC MEMBER CANTOR: I have two comments just pretty, pretty quickly.

One is just reflecting on the number of different plans that are out there. And particularly thinking from a local advocate perspective, thinking about how we as an advisory committee, the office can help to guide local advocates in understanding these plans. I personally have a hard time sometimes figuring out what the jurisdiction of the different plans are and what the key levers around certain issues are.

And I know that the Health in All Policies Task Force's purview is really with other state agencies so I'm really thinking more in terms of the office and the advisory committee, since one of the things we've talked about since the Willie Principle really is how we communicate information out and so really thinking carefully about that and where we -- how we help the public, advocates particularly, really understand how these different things interact and interplay.

And the second: You know, I think the conversation about evaluation is a really important one and there are a lot of different pieces to that. I think we should just have -- maybe have a longer conversation about that at some point. You know, evaluating Health in All Policies as one strategy to achieve population health. There's, you know, just different approaches to evaluating population health at a local level. Then there's a whole conversation about how

you actually evaluate equity and as an office how we're going to evaluate success.

And I think those are all different and complicated, interesting questions. I just didn't want to get that -- I don't want that to be lost because I think that would be a worthwhile conversation for us to have, particularly as we sort of move from the plan to the implementation discussion as a group.

AC CO-CHAIR GÁLVEZ: Thank you, Jeremy. Any other comments from committee members here?

Okay, so let's move to San Francisco.

AC MEMBER GARZA: No comments.

AC CO-CHAIR GÁLVEZ: Anybody at the Los Angeles Office?

AC MEMBER JOHNSON: No.

AC CO-CHAIR GÁLVEZ: Gail?

AC MEMBER NEWEL: Nothing.

AC CO-CHAIR GÁLVEZ: Okay, so let's now have public comment. I'll start here in the Oakland office. Anybody here like to comment on the Health in All Policies Task Force update?

Okay. The Sacramento office.

DR. NOLFO: Lilyane Glamben.

MS. GLAMBEN: Hi, this is Lilyane Glamben. I was wondering if there are any updates about the anticipated

participation by the CDCR and the committee to the task force?

MS. CAPLAN: Yes. This is Julia. So you're asking about the California Department of Corrections and Rehabilitation?

MS. GLAMBEN: Yes.

MS. CAPLAN: Earlier this year we did secure the official process through the Strategic Growth Council to add them to the task force so they are formally a member of the task force. So fair their involvement has largely been around our food procurement work and working to change some of the nutrition -- some of the food purchasing contracts at the state to make it easier for Corrections to meet their nutritional guidelines.

Corrections is also involved in some pilot projects around reducing recidivism and reentry, as are a number of other departments such as the Department of Justice. And so as we do our violence prevention exploration they will be actively involved.

MS. GLAMBEN: Thank you.

DR. NOLFO: Any other public comment? Yes, we do have --

AC CO-CHAIR GÁLVEZ: Any other members of the public in Sacramento?

DR. NOLFO: Yes.

MS. GIOVANNINI: This is Domenica from the Marin City Community Services District, Domenica Giovannini.

I just -- this was already touched on a little bit with the evaluation conversations on the impact. But especially with regard to the healthy food access, I feel like this work has been going on for most of my life. Which I can admit is not very long but it has been going on for a long time.

(Laughter.)

MS. GIOVANNINI: I mean, I talked about it in my public health training and in my undergrad. And so I hope -- I just want to reiterate, you know, not only the Health in All Policies Task Force but its related parties, that you really assess where your greatest impact is and the work that has already been done for the last, you know, 25 years. And most recently I think there's a lot of progress with, you know, the statewide Safe Street Program, the Heal Cities program, which is national. So that is my one recommendation.

DR. NOLFO: Any other members of the public? No.

Okay, in Sacramento we don't have any more, Sandi.

AC CO-CHAIR GÁLVEZ: Thank you. Los Angeles?

AC MEMBER JOHNSON: No.

AC CO-CHAIR GÁLVEZ: Okay, how about on the phone? And press *1 if you would like to make a comment.

THE OPERATOR: We do have currently two comments in the queue over the phone. Our first is from Ricardo Moncrief, your line is open.

MR. MONCRIEF: Greetings again. One comment on your upstream evaluation. The one thing -- I'm glad that you have my colleague there, Domenica.

One thing that I am a part of, a Board of Directors for a FQHC. In our community we have the largest public housing sector. And one thing about FQHCs, they keep numbers. And the public housing sector is located along the only corridor, highway, you know, in Marin County, north and south. And being located there they have a higher incidence of respiratory diseases or asthma and et cetera.

And my suggestion is, you know, and I think Jahmal mentioned it, about the presence of FQHCs is to use their -- their numbers, their baseline data, you know, to measure, you know, the impact of any other policies or the change in status through treatment of people exposed to respiratory ailments and things like that. I am only saying that to say that FQHCs are a valuable source of baseline data.

Also one other comment. I am hoping that there has been an interface with the Association of Bay Area Governments around transportation and housing. Having attended some of their meetings, they were very, very shy on environmental health impacts. And I'm glad that was brought

up because the gist of their conversations were around, you know, transportation hubs, et cetera, et cetera, and how it impacts on housings but very little about the integration of -- the significance of environmental health. So I'm glad that was, you know, put into the picture.

Thank you, that's all I have right now.

THE OPERATOR: Thank you. Our next speaker?

Our next comment comes from Robert Lipton. Your line is open.

MR. LIPTON: Hi. I'm one of the people at OHE right now. I wanted to reiterate how important issues around violence in communities really is. It's such a -- HiAP and the orientation and the fact that Jahmal is, you know, starting to really emphasize this. It is very important because it is not sort of some extra thing. The differential in the daily experience of violence across the age spectrum in different kinds of communities is an extremely important issue, both from a mental and physical point of view. It needs to be embedded in a kind of almost naturalistic way in our approaches. It has such a huge effect. It's kind of a zero-one thing. In communities that don't have high degrees of violence it doesn't -- the level of -- that issue becomes far less important. In communities with high degrees of violence it is an absolutely important thing that permeates through all aspects of one's life. And

I am very -- I am very -- I don't know if the word is "excited." I am very committed to working on these kinds of issues and helping those -- you know, to helping integrate those things in all manner of work we're doing.

AC CO-CHAIR GÁLVEZ: Thank you. So I believe that that's in for the public comment. Right? We asked all the sites, right?

Okay. So in the interest of time, we -- we have 25 minutes left for our meeting and three agenda items. So I am going to make an executive decision and our presentation on the DHCS update, we are going to table. It is my understanding that there is nothing timely that needs to be presented from this presentation. The fact sheets and some of the information can be shared through the weekly updates we get from the OHE staff.

So, Tamu, I'd like to invite you to talk about the future direction but near the end of the agenda item.

And then we need to leave a few minutes for receiving some public comment at the end.

DR. NOLFO: Okay, thank you, Sandi. And thank you, Neal, also for being flexible.

AC MEMBER KOHATSU: Sure, that's fine.

DR. NOLFO: Neal Kohatsu's PowerPoint presentation is posted along with the other PowerPoints for today but we can also check in to see if there are additional materials

that we want to send out before the December meeting.

We wanted to have as a standing agenda item to do updates from the HiAP task force and from DHCS because it is within our statute that those are the two entities that we coordinate with closely with the advisory committee.

But in the interest of time, because we really are looking at what is this advisory committee going to become and how do you want to spend your time on it, how can we best utilize your time and your expertise - and that goes into the planning for our next meeting, December 12th - I took the initiative to reach out to the advisory committee members and see if you would be willing to do phone interviews or in-person interviews with me if you were here in Sacramento. And many of you heeded the call and so I appreciate that. And I just wanted to give you kind of a snapshot of what I got back from those interviews.

So one of the things that I wanted to know is if there are specific areas of the strategic plan implementation that you would like to be involved in? And about half of you are still kind of mulling over the draft strategic plan and seeing where that might make sense for you.

About the other half of you identified areas that make sense in terms of your own professional and personal backgrounds and commitments of where you would like to

insert yourself or potentially your agency or your organization or center in helping to move forward the work of the strategic plan.

There was also a discussion that I had with you about the potential for doing or for participating in subcommittees. And it is in your bylaws that that's an appropriate role to take on is to be a part of subcommittees. Everyone that I spoke with said yes, that was something that you were interested in. That you thought that that was a good use of your time.

And really it came down to, do we charge right into it right away, maybe leaping in, you know, our December 12th meeting starting out with subcommittee work; or being more thoughtful in planning the preparation around what does this really mean; how can we make sure that we get on the same page with these subcommittees? To just be more thoughtful about how it is that we want to move into doing that subcommittee work. And so that can be part of the discussion after I present this.

There were five potential subcommittees that had been suggested, thrown out there as ideas by Jahmal, and so I put those ideas out there to you to ask what your interest might be.

One of them was community development and engagement, which would go along with the communications arm

of the strategic plan, looking at strategic alliances, possibly advocacy work within your constituent communities. And there were a lot of folks who were quite interested in that so it looks like you'd have about 9 or 10 members of the advisory committee who would be interested in serving on that subcommittee.

And some of you only indicated one subcommittee, some indicated multiple subcommittees that you would be interested in and willing to serve on.

Policy also had about an equal number of individuals who would be interested in serving on that subcommittee, about 12. Around policy we were looking at the intersections with the HiAP Task Force, with potentially the new Boys and Men of Color Task Force. So those kinds of intersections around policy.

There was another subcommittee idea that was thrown out around climate and environmental health. And this had the fewest number of takers, it had about four or five of you. Mostly that was because people said it was an area that they still learning about, not that they weren't interested in it. In fact, people were very interested in it but just didn't necessarily know that they had the expertise to be able to serve effectively on that subcommittee. And so that may be an opportunity to bring in additional community members or experts to be a part of that

subcommittee staffing.

The fourth one that we put out there was health research and statistics and that one had about four or five takers on it. And that's really looking at that assessment arm of the strategic plan. What are we doing with data? How are we manipulating it? What kind of recommendations do we need to make around data?

And then the last one was education training and development. And we really saw this as mapping onto the infrastructure arm of the strategic plan, the capacity building. And there were about eight or nine that were interested in that particular subcommittee.

So once again, it was kind of this question of, do we want to kind of charge in, roll up our sleeves and start with these subcommittees in December? Or as one member said, I would want to understand the purpose and objectives about the subcommittees and are these the right ones before we decide. So to have more deliberation and thought before charging into them.

And then I got some input about people's particular backgrounds and expertise and how that may aid in the subcommittee work.

There were a couple of people who said things like, always the challenge is the time and to be realistic about it. If we meet during the regular committee meetings

that would be great. So people were very interested in piggy-backing the subcommittee meetings onto the full advisory committee meetings. The subcommittee meetings are subject to Bagley-Keene the same way that the full advisory committee meetings are and so there would actually need to be agendas and materials and whatnot posted in the same fashion. But they could happen concurrently. So we could have four or five subcommittees happening at the same time at the same location and members of the public could decide which of those they wanted to be a part of. I am not quite sure how we would work out the audio portion of that if we were in a site like the Sierra Health Foundation or something like that. So some of the logistics would probably need to be thought through a little bit around that but it's not insurmountable. And yes, so Katie, perhaps you can weigh in on that when there is more discussion on that. But people were very much in favor of the subcommittees and the full committee taking place in concert.

I also asked about how you feel your expertise can best be utilized on the advisory committee now that the strategic plan has been developed. There were a lot of people who said that they really felt like they could be a community liaison or serve in a community engagement function, which is also built into the purpose of the advisory committee and into your bylaws that you help to

essentially inform OHE about what is going on in communities and serve as that conduit also with the two-way communication back into communities.

One of the quotes that I have there is: "You are multiplying the reach and penetration of the Office of Health Equity by having an advisory committee that has in turn a network. It's like becoming an octopus with so many different tentacles. You can continue to use us to leverage the populations in areas that we represent." There were a number of people who spoke to that.

Folks also were very interested, as I said, in getting organized in subcommittees. You felt that that was a good use of your time.

One of the ideas that came up by one of the members was to essentially layer on to the subcommittees, having cultural or professional identity tracks. And you could kind of see that happening even with the discussion this morning with the CRDP around a lot of mental health expertise and weighing in on that. And so that was where that came from was that perhaps there could be a mental health track but also maybe an LGBTQI track or people interested in Latino issues or other ethnic groups. And so that there may be another way of kind of ensuring that that expertise is present within the different subcommittees or having another layer to be able to go to to advise on the

subcommittee. So that's something else to kind of think about with the subcommittees.

One person said that in terms of utilizing their expertise, they wanted to determine both the best practices to be disseminated and the funding streams to enable that. So starting to think about, you know, how is it that we are going to implement the strategic plan.

And then I thought this comment was interesting too: To best support those who are responsible for implementing the plan. That principle is really important as an advisory committee. You don't want to just pile more work onto the people or be pie in the sky. Our expertise should complement what the staff wants to do. There may be pieces that the advisory committee can own. Where does the strategic plan align with my work, with my funding? It would be interesting to inventory the issues where we have expertise or interest or capacity. But we need to hold the big equity tent and not let it become fragmented.

I also asked, what else would you like to accomplish as part of this inaugural advisory committee? What is your vision for its future? There were a lot of folks who said monitoring and implementation, developments and evaluation of the strategic plan. That the advisory committee is t he public and their responsibility is to hold the staff accountable. So really making sure that there are

updates on the movement with the strategic plan. And actually that's built into the strategic plan. So assuming that the version that has been submitted comes out the way that's been submitted. That is actually one of the goals in the strategic plan is that there would be quarterly updates on its implementation, both at the advisory committee meetings and posted on-line as well.

And to ensure implementation is mindful of constituent communities. A number of you said that as well, that you really want to make sure that the communities that you represent don't get lost within the implementation.

To be involved in the plan's implementation and oversight through the subcommittees.

And there were some other interesting comments that came out that people really thought would be of value moving forward as the advisory committee, such as ensuring that this vision that we have at the statewide level around the Office of Health Equity actually gets moved down into the local level with the local public health offices. And that there would be the same kind of tools that we are using at the state level that get pushed down at the local level and that the advisory committee makes sure that that happens.

But really figuring out a way to put the strategic plan in action. Once again looking at funding streams.

And there were a couple of people who were interested in really making sure that the advisory committee stayed on point with the social determinants of health. That they felt a little uncertain whether or not the advisory committee was really up to the task of ensuring that it goes after the social determinants of health, which are harder to justify sometimes. Because as we have talked about, they are harder to evaluate. They take longer in order to see the results. And so what can be done to really push the envelope in that way and keep that vision strong.

And there were people who basically said, I really want to get concrete like trying pilots in particular cities. To really make the plan as concrete as possible. To really start implementation on the plan.

And then in terms of recommendations or strong preferences for the plannings of the meetings moving forward. To be able to have input from the advisory committee members about the agendas. That was noted by a couple of people. To do the dual calendaring, which we did to come to the December 12th date.

A couple of different ideas about the December meeting specifically. There was one comment that for the December meeting to do a really good review of the final strategic plan and the demographic report, the implementation plan, the evaluation plan and have it really

focused in that way.

And there were others who really felt like it was important to jump in and do a lot of work with the subcommittees.

In terms of the length. There was definitely a lot of variety in terms of whether people were into one day meetings or two day meetings. But basically people felt like two days is a long time but it's a lot to give up. And there was an understanding of why that happened initially because there was so much to do initially. But that moving forward that was probably a bit too much to ask. There were other people, however, who really felt like they would prefer to have fewer two day meetings than to have more one day meetings. So that's something to consider as well.

In terms of the structure and format. A lot of people said we should meet face to face at least twice a year and if necessary more. But there were a number of you who said that it's hard to pick up on body language and that kind of thing if you are not face to face. That face to face was important to a number of you.

However, I also got that strictly business items or subcommittees would be okay by phone conference. There were a few of you who said that.

And that there were some of you who also liked the idea of trying out the technology and having shorter

meetings and being able to use the technology where it is appropriate. To not have to do everything face to face. For some of you you're very, very busy and getting away for a day is really a hardship.

And we'd even noticed with some advisory committee members like Dr. Paula Braveman, it is very hard for her to show up at all because her schedule is so busy. And she has things on the calendar like years in advance like something for today.

Also that the subcommittees and the report-outs and other small group work should take place at the meetings. People really like the idea of working in small groups at the meetings; that that's valuable.

With the content: People have really enjoyed the presentations. We had a lot of comments to that effect. That people felt like the presentations needed to continue to educate ourselves and stimulate thought and make connections among areas of expertise and develop partners. But that future presentations should really focus on new developments.

And that there were several of you who really felt that we should be bringing in people who have achieved success somewhere else around the social determinants of health, even if it is from outside of California. So to use the presentations to really elevate our understanding of

what can be done around the social determinants of health and to capitalize on models, even if they are from outside of the state.

There was the idea to utilize webinars to disseminate information that is not so accessible by reading it. So potentially in-between meetings to do webinars for those who are able to do that as a learning.

And to do occasional check-ins like the interview process that we just went through.

And then there was also information that I gathered from you around policy issues. Which was really a way to kind of gauge what interests you the most. What are you most passionate about? And that we can use that within the Office of Health Equity essentially like marching orders to go back and continue to do research in those areas or to be able to bring presentations to you that would help to eliminate what can be done in these particular policy areas.

So I won't go into the specifics around that, I know that we are short on time, but that was basically in nutshell what I got from you. I still have a few more members to speak with and I will continue to kind of update where we are with that.

Patricia Ryan has a question.

AC MEMBER RYAN: I don't recall being contacted.

DR. NOLFO: It was just an e-mail that went out to

everyone but I'd be happy to reach out to you again.

AC MEMBER RYAN: Well I'm wondering if -- I think you have two e-mails for me and one of them is the old e mail and one is the new e-mail. I would be happy to talk to you, I just didn't see anything.

DR. NOLFO: Thank you. Is there anyone else in the Sacramento office that wants to -- Sacramento site that wants to weigh in? Neal.

AC MEMBER KOHATSU: Just a quick comment on work groups. It may be that, at least initially, there are ad hoc work groups that target a -- and I don't have anything against the work groups that were discussed. Obviously data evaluation is an ongoing area. But within that there may be things that another group hones in on and then we kind of see over time the need for standing groups. In many organizations you have both, you have a limited number of standing work groups and then ad hoc work groups and maybe there will be some combination in the future.

DR. NOLFO: Thank you.

OHE DEPUTY DIRECTOR MILLER: I'm going to jump in. This is Jahmal. Just quickly.

I know we'll kind of have more of a methodological approach to getting the feedback. But I particularly wanted to hear after Tamu has shared this information with us, just kind of some sentiments and thoughts from Sandi, our Chair,

and from Rocco. I am not looking for anything in particular but just based on what you heard. I would definitely want to hear from the both of you.

DR. NOLFO: Go ahead, Rocco.

AC MEMBER CHENG: No, no. Let Sandi.

DR. NOLFO: Sandi, do you want to weigh-in first?

Rocco joined us, by the way.

AC CO-CHAIR GÁLVEZ: Oh, great. Tamu and I did have an extensive conversation about starting to think about how to do the December meeting. My thoughts on this are that I think it's premature to split off into subcommittees without having further understanding of kind of what the parameters of each committee is. I have been part of projects where we just split off into subcommittees without kind of looking at the forest --

OHE DEPUTY DIRECTOR MILLER: Right.

AC CO-CHAIR GÁLVEZ: And then the trees, they each start doing their own thing and they don't, they are not necessarily working in tandem towards the big picture anymore. And then there ends up being a lot of overlap of, you know, that the different subcommittees end up starting to work on very similar things.

So for me, I think in order to be most effective I think we at our next meeting need to have a little more of a group discussion on what the subcommittees could look like.

If there are any additional subcommittees we think there should be and what the parameters and kind of big picture goals for each of those committees would be prior to having folks decide which committees they would want to be on. So that, I mean -- So that was kind of, that was one of my thoughts.

The other thought that I felt was important was that I feel that we are not experts. I mean, primarily almost everyone on this task force, short of Linda, are primarily health-type people. Mental health, physical health, you know, focusing on youth, focusing on specific populations, health policy. We tend to be folks from that area. And I think that we don't have collective expertise, you know, deep expertise on the different social determinants of health.

And so I think if that is part of our charge I think we need to get a lot more informed about more, you know, a lot more guidance on best practices, on best thinking. On, you know, what are some of the key equity issues in these different arenas, the key connections between these arenas of health outcomes. And so I think that that's something that we need to be thinking about moving forward. That with every meeting we try to build our collective understanding of the different social determinants and their impact on health outcomes. So those

are my key thoughts.

AC MEMBER CHENG: Hi everyone, this is Rocco. I mostly agree with what Sandi just shared. And I want to say, appreciation to Jahmal for suggesting the subcommittee structure. I think it is a good and effective way of utilizing people's expertise and time.

I agree that we should probably get together and work out some of the details and make sure the direction is the one that we get a buy-in from this advisory committee and then we move forward after that.

OHE DEPUTY DIRECTOR MILLER: Okay.

AC CO-CHAIR GÁLVEZ: Okay. Are you done, Tamu? Should we -- are we ready now to get comments from anybody else and the public?

DR. NOLFO: Yes.

AC CO-CHAIR GÁLVEZ: And we only have a few minutes.

DR. NOLFO: Yes, go ahead.

AC CO-CHAIR GÁLVEZ: Okay. So any other folks of the advisory committee that would like to comment on this? I'll start there with the Sacramento group.

DR. NOLFO: No takers in Sacramento.

AC CO-CHAIR GÁLVEZ: Okay. San Francisco?

UNIDENTIFIED SPEAKER: Yes, we've got a comment.

AC MEMBER LU: This is Francis. I'm just

wondering about possibly doing both/and. And that is, for the next meeting, as Sandi said, we need to focus on the final report and all of that. But also make sure that we do have some time to really work on the small groups and get them functional after that December 12th meeting. I think that would be the way we can really help bring our specific expertise to the specific issues that we need to deal with.

AC CO-CHAIR GÁLVEZ: Thank you. And I was definitely thinking of moving in that direction at the December meeting, just not initially splitting right off into the committees until we had more of an opportunity to flesh out what they were about and what were the parameters for each one.

Any other, any other comments at San Francisco?

Okay. In Los Angeles?

AC MEMBER PARKS: This is Hermia. In the interest of time I certainly agree with Sandi and Rocco comments regarding that.

AC CO-CHAIR GÁLVEZ: Okay, any other comments in Los Angeles?

AC MEMBER JOHNSON: No.

AC CO-CHAIR GÁLVEZ: All right. And then Fresno?

AC MEMBER NEWEL: No, thank you.

AC CO-CHAIR GÁLVEZ: Okay, how about members of the public specifically to this item? In a moment I'll

allow for public comment about anything else. Specifically to this item, any public comment here in Oakland?

Sacramento?

DR. NOLFO: Any public comment?

No.

AC CO-CHAIR GÁLVEZ: Los Angeles?

AC MEMBER JOHNSON: No.

AC CO-CHAIR GÁLVEZ: Okay, how about on the phone? Is there any comment that people want to make specifically to this item on the phone? If so, please, *1.

THE OPERATOR: We do have a comment over the phone from Ricardo Moncrief, your line is open.

MR. MONCRIEF: Yeah. I would have a big concern that, being a small community again, I reiterate that we are able to move a little bit faster and we are able to develop, you know, innovative tools that we hope will change the paradigm, you know. We have infrastructure tools, mental health, monitoring and tracking, we have communications, the lady sitting across from you has some good ideas and marketing nonprofits.

And we would like to know, you know, how community engagement works a little bit more, you know, and we'd like to share, you know, the ways that we are using to map out health determinants. So, you know, community engagement, who do we contact? I know Jahmal has been down to the

community one time but we feel the necessity to bring him back again along about 2015, hopefully in January. So how would that work?

AC CO-CHAIR GÁLVEZ: Jahmal or Tamu, you want to answer that?

OHE DEPUTY DIRECTOR MILLER: Yes. So I would encourage looking forward to the subcommittee opportunities to serve as a vehicle to ensure that, you know, the voice of Marin city is represented. I don't know if you have made -- maybe you've heard about the different times that I have spoken across the state. I always talk about --

MR. MONCRIEF: Yes.

OHE DEPUTY DIRECTOR MILLER: I always talk about what's happening in Marin City.

And with respect to communications, I remember the comment at probably our May meeting that you shared around ensuring that, you know, from a communications perspective we are engaging with you guys. Regardless of whether you are a small community or not, I know that there is a high need there. And I would just leverage existing vehicles and the direct relationship that you have with us to ensure that not only your voice is heard but there are some actionable opportunities. I mean, what you guys are already doing to some extent is really part of an implementation of our plan. So we can formalize that a bit more but you won't be, you

won't be left out.

MR. MONCRIEF: Thank you.

AC CO-CHAIR GÁLVEZ: Okay. So at this moment I would like to invite the public to speak on any other items that you would like to speak on that weren't necessarily items on the agenda.

I'll start here at the Oakland office. Were there any items that either of you wanted to comment on?

Sacramento?

DR. NOLFO: No, no takers here.

AC CO-CHAIR GÁLVEZ: Los Angeles?

AC MEMBER JOHNSON: No.

AC CO-CHAIR GÁLVEZ: And on the phone, any other items that you would like to speak to that have not already been spoken to?

THE OPERATOR: There is no one in the queue at this time.

AC CO-CHAIR GÁLVEZ: All right, thank you. We are a few minutes past time.

I do want to thank you all for the patience of our -- and sitting through our little experiment here trying to do a multiple site interactive meeting, which I think was a little bit challenging. I don't think we have time at this time to really debrief how that went but I would invite you all to think about it and when we come back together in

December we have some wisdom around how do we plan our meetings moving forward. If we want to do phone meetings again, what lessons we learned from this experience. And then we can leave a little bit of time for that at the next meeting's agenda.

With that, I hope you all have a good rest of your week and I look forward to seeing you all in December.

OHE DEPUTY DIRECTOR MILLER: Sandi, I just want to make a quick, final comment.

AC CO-CHAIR GÁLVEZ: Jahmal.

OHE DEPUTY DIRECTOR MILLER: No problem. I want to just reiterate a concept that we want to talk about more and that is -- it's come up around sustainability. Whether it's around CRDP or the HiAP or the Office in general. I am really trying to think about ways in which we can all strategically just hardwire sustainability for this work. Whether it's, you know, the $60 million we have allocated for the next four years around our mental health disparities work, I am already thinking beyond that four years. How do we sustain Health in All Policies?

And overall one of the reasons why I want to bring the private foundations to the table is to really catalyze important work that we want to do now. But we ultimately know that policy is the strongest tool that we have to wield to really hardware and sustain this work. So let's just

keep that at the forefront of our mind so that as all of us, when our tenures conclude, whenever that is, that from an institutional perspective this work continues. And it is not subject to leadership, it is not subject to just someone's, you know, arbitrary decision but it is built in to our systems.

And lastly, I just wanted to recognize Ellen, Ellen Wu from the Urban Institute who came to present to our executive management team at CDPH. Provided some excellent information and as a result I think we have some opportunity there to collaborate. Once again, to internally educate our colleagues in state government around this health equity work.

And then lastly, there is a book -- I want to get extra copies from -- it's the National Association of County and City Health Officials, NACCHO, NACCHO, whatever it's called.

AC CO-CHAIR GÁLVEZ: NACCHO.

OHE DEPUTY DIRECTOR MILLER: NACCHO. They just produced a document called "Expanding the Boundaries. Health Equity in Public Health." It's a short read but it's very, very powerful. Talking about how that integration looks with respect to social determinants of health and talks about the impact of decades of decisions with respect to, you know, the unintended consequences of many policies

of how it's lended itself to what we see today as structural racialization and other social inequities. And I want to make sure not only that our staff has it in the office but that we get copies for the advisory committee.

But I specifically wanted to recognize BARHII who was cited throughout that document, HiAP too, but BARHII is cited from beginning to end on a national level. And that work, from a downstream/upstream perspective, is integrated into that report. And I just wanted to acknowledge them for the work that they have done and I want to ensure that we each get that document. I think it will provide some great insight that can inform our next meeting and our future, future steps.

So with that said I am done and thank you everyone. This was far from disastrous. It went extremely well. No, there are some things that we'll tweak but overall I feel really good about this technological approach to doing this meeting.

AC CO-CHAIR GÁLVEZ: Thank you, Jahmal, and thank you everybody.

(Thereupon, the meeting adjourned at 12:09 p.m.)

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CERTIFICATE OF REPORTER

I, John Cota, an Electronic Reporter, do hereby certify that I am a disinterested person herein; that I recorded the foregoing California Department of Public Health, Office of Health Equity Advisory Committee meeting; that it was thereafter transcribed.

I further certify that I am not of counsel or attorney for any of the parties to said meeting, nor in any way interested in the outcome of said matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 17th day of October, 2014.

/s/ John O. Cota

JOHN O. COTA

CERTIFICATE OF TRANSCRIBER

I certify that the foregoing is a correct transcript, to the best of my ability, from the electronic sound recording of the proceedings in the above-entitled matter.

/s/ Ramona Cota

RAMONA COTA, CERT**478

October 17, 2014